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"People helping people help themselves"

January 21, 2014

Cindy Mann, JD
Deputy Administrator and Director of CMCS
Center for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244

Dear Director Mann:

Pursuant to the Special Terms and Conditions for the Health Indiana Plan (HIP), Indiana's Section 1115 Medicaid demonstration project, I am pleased to submit our annual report for calendar year 2012.

Indiana looks forward to receiving CMS' comments for incorporation into the final report.

Please direct comments on the report to the attention of Pat Nolting at pat.nolting@fssa.in.gov, or (317) 232-4318.

Sincerely,

[redacted]

Joseph Moser
Medicaid Director

Cc: Verlon Johnson, Associate Regional Administrator, Chicago Regional Office
Wakina Scott, CMS, Mail Stop S2-01-16
Elliot Fishman, CMS Director, CAHPG

HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00237/5

SECTION 1115 ANNUAL REPORT

Centers for Medicare and Medicaid Services

REPORTING PERIOD:

Demonstration Year: 5 (1/1/12 - 12/31/12)

www.HIP.in.gov

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SECTION 1: EXECUTIVE SUMMARY

Seven months after the Indiana General Assembly passed bipartisan legislation to create the program, the Healthy Indiana Plan (HIP) began to enroll working-age, uninsured adults on January 1, 2008. HIP is the nation's first high-deductible health plan with health savings accounts (HSA) model for Medicaid recipients. The State and HIP beneficiaries jointly make monthly contributions to a Personal Wellness and Responsibility (POWER) account, which funds an eleven hundred dollar deductible (the amounts of member contributions vary by income level).

The HIP program targets uninsured adults between ages 19 and 64 that have income under 200 percent of the federal poverty level (FPL). They must also have been uninsured and not have access to employer-sponsored health coverage during the six months before they apply for the program to discourage crowd-out of private insurance. The HIP program is not intended to cover all of the eligible population, but per the legislation only the number of individuals that revenue sources (cigarette taxes and DSH payments) can support.

Most HIP members are required to make a monthly contribution to their HSA-styled Personal Wellness and Responsibility (POWER) account (between two to five percent of their family income). The monthly contributions and POWER accounts are designed to encourage HIP members to take responsibility for their health care. Covered services are initially paid by the POWER account funds. To encourage the use of preventive health care, the first $500 in preventive care services are not charged against the POWER account.[1]

As of December 31, 2012, and after 60 months (5 years) of program operations:

- The State had received 411,568 HIP applications; of those, 75,172 (18 percent) were submitted in 2012.
- 105,197 unique individuals had ever been enrolled in HIP.
- In 2012, 68.9% of those enrolled in HIP were caretaker adults, and 31.1% were non-caretaker adults. The HIP population mix of caretakers and non-caretakers has shifted since 2009 when the non-caretaker cap was imposed (at the end of 2009, 47.8% of those enrolled in HIP were caretakers and 52.2% were non-caretakers).

A number of indicators suggest that HIP is valued by its members, and that the program's design effectively promotes conscious consumption of healthcare services. In 2012, 94 percent of individuals that were determined eligible for HIP made their first required monthly contribution

[1] During the first year of the demonstration, the health plans did not charge any preventive service use against the POWER accounts. Starting in mid-2009, Anthem imposed the $500 limit on preventive care and services above that limit were charged to the member's POWER account. MDwise and MHS continued to offer unlimited preventive services through 2012.

to their POWER accounts and became full members, and 93 percent made subsequent contributions to remain enrolled. This indicates that contributions are affordable for members. The majority of HIP beneficiaries indicate willingness and ability to contribute to the cost of their health care coverage, and that they value having it. Analysis of the 2013 Mathematica Policy Research HIP member survey indicates that the majority of HIP beneficiaries believe that the amount of their monthly POWER account contributions is the right amount or in fact, too low, and that they would be willing to pay more to remain enrolled in the program. The required POWER account contributions do not appear to impose financial burden on beneficiaries, either. Only 14 percent of former HIP members reported that cost-sharing was their reason for leaving the program—they were much more likely to report other reasons, such as gaining other insurance coverage, an increase in income, or not returning enrollment paperwork. Most HIP members (83 percent) prefer making up-front monthly payments with the opportunity to have unspent funds returned instead of making a payment each time they visited a health professional, pharmacy, or hospital. The survey also found that 96 percent of HIP members were either somewhat or very satisfied with their overall experience with the program.

HIP uses incentives to promote appropriate healthcare utilization, and in 2012, 60 percent of members received at least one recommended preventive service for their age and gender. To discourage inappropriate ER usage, the program charges co-payments for non-emergent visits. In 2012, only 31 percent of HIP members visited the ER, compared to 38 percent of adult Hoosier Healthwise members (traditional managed care Medicaid). Additionally, 5 percent of members reported deciding to seek care at an urgent care center or their regular doctor instead of the emergency room because of the co-payment.

HIP continues to meet budget neutrality requirements and state costs do not exceed the funding available for the program. These fiscal results are partially due to the cost containment measures taken in earlier years, but also reflect the state's closure of the program to non-caretakers who tend to be older and have more chronic conditions compared to caretakers. This closure was implemented in March 2009.

The HIP program has experienced a variety of successes to date, discussed in detail throughout the rest of the report. These successes lend strong evidence to the effectiveness of using a consumer-driven health plan model to insure a low-income population. Evaluation results demonstrated that this model can effectively promote appropriate healthcare utilization while staying well within budget neutrality limits and protecting some of the most vulnerable citizens from unmanageable medical costs.

SECTION 2: INTRODUCTION

HIP was designed to provide health insurance coverage to low-income Hoosiers who do not have access to health insurance and are not eligible for Medicaid. On December 14, 2007, HIP was approved as the Indiana Section 1115 Medicaid Demonstration Project (11-W-00237/5) for a five-year period – January 1, 2008, through December 31, 2012 – in accordance with section 1115(a) of the Social Security Act., Indiana has been granted two waiver extensions and the demonstration is currently set to end on December 31, 2013. This demonstration provides health insurance coverage to working-age adults who are not eligible for Medicaid and who have a household income below 200 percent of the federal poverty level (FPL).
This demonstration is the first of its kind in the United States and uniquely empowers members to be cost- and value-conscious health care consumers. It also has a uniquely strong emphasis on personal responsibility and consumer value-based purchasing. HIP members:

- Make monthly contributions to their Personal Wellness and Responsibility (POWER) accounts ranging from two to five percent of gross family income[2]
- Manage their POWER accounts through debit cards and monthly statements
- Incur penalties when they do not submit their monthly contribution within 60 days or do not submit information needed for the redetermination process in a timely manner, which includes disenrollment from the program and remaining ineligible for 12 months
- Have financial incentives to obtain yearly preventive services (as specified by the State and based on age and gender)
- Lower their monthly contributions when unused POWER account funds are rolled over from one year to the next; and maximize the size of the rollover if they receive the preventive services specified by the program.
- Do not have to make co-payments for services, except for non-emergent emergency room (ER) visits.[3]

All Section 1115 Medicaid research and demonstration waivers are required to be budget neutral—the demonstration may not cost more to the federal government than it would have cost had it not been implemented. The estimated total computable budget neutrality limit for the five years of the demonstration is $10,451,800,822. Over the past five years of the demonstration, the HIP program has cost just over $1 billion (just under $465 million for caretakers and about $539 million for non-caretakers). When this figure is added to the five years of expenditures for the

[2] Monthly contributions are not required if a member does not have any income or if the family is already spending 5 percent of its income on premiums and cost-sharing requirements for family members covered by Medicaid of the State Children's Health Insurance Program.

[3] ER co-payments are refunded to caretaker adults if the ER visit results in a hospital admission or is determined to be emergent. Non-caretaker adults do not receive refunds under these circumstances.

XIX Mandatory Populations ($8.4 billion), the cumulative waiver margin is $1.1 billion[4]. The Special Terms and Conditions (STCs) that govern the demonstration allow Indiana to use a portion of its Disproportionate Share Hospital (DSH) funds and managed care savings in the program's budget neutrality calculations. The HIP is also funded by a portion of a cigarette tax which was implemented July 1, 2007.[5] This report evaluates the fifth year of operations, calendar year 2012. An overall summary of the year is provided, followed by an evaluation of the goals of the program as listed in the original 1115 waiver. The State of Indiana respectfully submits its Fifth Annual Healthy Indiana Plan Section 1115 Demonstration report to Centers for Medicare & Medicaid Services (CMS).

[4]Source: Milliman Budget Neutrality Waiver Renewal Report to the Family and Social Services Administration, July 2013.

[5] At that time, the cigarette tax rose 81 percent, from $0.550 to $0.995 per pack.

SECTION 3: ACCOMPLISHMENTS

In 2012 the HIP program had accomplishments in all areas.

Enrollment and Program Take-Up Rates/Impact on Uninsurance

- By December 2012 - the close of the fifth demonstration year - the HIP program had served a total of 105,197 Hoosiers. On average, 40,721 Hoosiers were enrolled in HIP each month between January 2008 and December 2012. Total enrollment peaked in September 2009 at 50,339 members.
- The uninsured rate for Hoosiers with incomes under 50 percent of FPL has *decreased* from about 47 percent in 2005-2007 (prior to HIP implementation) and held steady at approximately 43 percent between 2008 and 2012. Uninsured rates for other income groups HIP covers above 50 percent of FPL (up to 200 percent of FPL) have increased since before HIP was implemented. The increase in the uninsurance rate among other income groups is likely due to external factors such as the national economic recession and high unemployment rates during the HIP implementation period. It likely would have been higher without HIP.

Fiscal Conditions

- As in previous years, the State took steps in 2012 to ensure that HIP meets federal budget neutrality and legislative requirements dictating that funding would be adequate to support enrollment. One step included keeping the program closed to new non-caretakers (also known as childless adults) throughout 2012.

- By the end of 2012, the HIP program had cost approximately $1 billion over the course of its five years, staying below the five-year waiver margin.

Operational Accomplishments

Operationally, the HIP program was in a steady state and no notable operational changes were implemented due to the uncertainty associated with HIP's future.

POWER Accounts

- In 2012, most HIP members (77 percent) were required to contribute to their POWER accounts. Of those who received a full subsidy, 95 percent had incomes under 100 percent of the FPL.

- Through the end of 2012, about 35 percent of member POWER accounts contained funds after 18 months of member enrollment. Sixty-five percent of these accounts received partial rollovers (member-contributed funds only), and 35 percent received full rollovers (member and State-contributed funds).

Evaluation/Program Design Accomplishments

HIP has demonstrated successes in using the model of a consumer-driven health plan for a low-income population. In addition, HIP has effectively promoted preventive care utilization and discouraged inappropriate emergency room use.

- The majority of HIP members report that they prefer to make a fixed monthly payment to the POWER account with the opportunity to receive unspent funds back over making copayments each time they seek medical care. In Mathematica's 2013 survey of HIP enrollees, 83 percent of survey respondents said they preferred to pay up front each month over paying each time they visited a health professional, pharmacy, or hospital. This finding lends support to the HIP contribution approach (funding POWER accounts based on income) as opposed to co-payments.
- Most HIP members feel that their POWER account contributions were reasonable. According to Mathematica's 2013 survey, among those who made a monthly contribution to their HIP POWER accounts, approximately three quarters of current HIP members felt that their monthly contributions were "the right amount," and nearly 85 percent believed the amount was either right or below the right amount. Overwhelmingly, members reported that they would be willing to pay more to remain in HIP. In 2012, 94 percent of members made the first required contribution to the POWER account and 93 percent made subsequent contributions.
- HIP is effective at promoting the receipt of preventive care. In 2012, 69 percent of female HIP beneficiaries and 39 percent of male HIP beneficiaries (60 percent of the overall HIP population) received at least one age-appropriate recommended preventive service, according to a claims analysis. Members who were required to contribute to their POWER accounts used preventive care at higher rates than non-contributors, perhaps because of the incentive to receive a full rollover and reduce required contributions in the next year if services were obtained.
- HIP is effective at reducing inappropriate emergency room usage among beneficiaries. Only 31 percent of HIP enrollees visited the ER in 2012, as opposed to 38 percent of adult Hoosier Healthwise (managed care Medicaid) enrollees. In the 2013 Mathematica survey, 5 percent of HIP beneficiaries decided to go to an urgent care center or their regular doctor to seek care because of the co-pay required for non-emergency use of the emergency room.

SECTION 4: POLICY AND ADMINISTRATIVE DIFFICULTIES AND SOLUTIONS

The effect of Affordable Care Act on HIP continued to be a significant policy and operational challenge in 2012. Since the passage of the ACA, Indiana has repeatedly sought guidance regarding the future of HIP. In September 2012, the State received notice of a one-year extension of the waiver, which served as a short-term reprieve but maintained the long-term uncertainty about the program's existence. The uncertainty has impacted enrollment and all operational improvement and maintenance projects have continued to be on hold.

The original 1115 demonstration waiver authorizing HIP was approved for five years, with an expiration date of December 31, 2012. The Indiana Family and Social Services Administration submitted an 1115 waiver renewal request on December 28, 2011 and requested the renewal for the maximum three-year allowable time. In September 2012, Indiana was granted a one-year extension of the program. A new waiver application was submitted in early 2013, and in September, Indiana was granted permission to extend the HIP program for an additional year (through December 2014). The Special Terms and Conditions mandated a decrease in the income level at which Hoosiers are eligible for HIP, due to federal subsidies that will be available for those over 100 percent of the FPL to purchase coverage on the federal Marketplace.

SECTION 5: PROJECT STATUS

5.1 OUTREACH AND PLAN ACTIVITIES

A. OUTREACH

The three Managed Care Entities (MCEs) that contract with the state (Anthem, MDwise, and MHS) continue to conduct outreach and marketing activities for the HIP program. All three MCEs have active marketing programs, and regularly organize and participate in community events to raise awareness of the HIP.

Anthem

In 2012, Anthem's outreach staff participated in over 375 events to provide information on HIP and HHW (Hoosier Healthwise, Indiana's Medicaid risk-based managed care program for pregnant women, very low-income parents, and children). Outreach activities seek to promote the HIP program by educating members on HIP benefits and the POWER account, and by promoting cost-conscious health care decision-making and preventive care among members. Further, Anthem utilizes HHW outreach events as an opportunity to promote HIP. During Anthem's 34 Clinic Days, held throughout the state to promote preventive health services for children enrolled in HHW, applications for HIP were distributed to caregivers.

Anthem utilizes partnerships with faith-based organizations, minority health organizations, government agencies, Work Force One, Covering Kids and Families participants, public libraries, retail stores, pharmacies, and community health organizations to reach its target populations. Outreach specialists have traveled to food pantries to educate members about HIP transportation benefits and emergency room (ER) usage; participated in Men's Health Week at Federally Qualified Health Centers (FQHC) to raise awareness of preventable health issues and encourage early detection and treatment for diabetes, HIV, and other conditions; and presented at college health fairs. Outreach Specialists have built relationships with local Family and Social Services Administration's Division of Family Resources throughout the state, allowing them to present during monthly IMPACT classes (job training and education for TANF and SNAP recipients) During these presentations, Outreach Specialists provide an overview of the HIP program, including the application process, POWER account requirements, and the availability of transportation. Anthem also works with medical providers to offer individualized member outreach. Providers can refer members who miss appointments or who might benefit from health education classes, connection to community resources, or an explanation of member benefits.

Anthem staff has made efforts to specifically reach out to Allen County's Burmese community. Recognizing the cultural and language barriers faced by this population, Anthem developed alternate processes for access to customer services and provided specialized assistance in accessing preventive health services and education. Anthem has collaborated with the other MCEs to conduct open houses for members from Burma/Myanmar. These open houses offered

education on how to schedule doctor's appointments, secure transportation, manage their health care, and understand their HIP plan benefits.

Each new HIP member who enrolls in Anthem receives a welcome call from a Health Needs Specialist to inform them about plan benefits, including access to preventive care, coverage for doctor's visits and hospitalizations, and the POWER account. During the call, the member is given the opportunity to select a primary medical provider (PMP) and to complete a health risk assessment. HIP members also receive customized MyHealth Notes, which remind members to get regular preventive care, encourage the correct use of prescription drugs, and promote overall wellness.

MDwise

During 2012, MDWise staff conducted outreach at over 100 school events (including after-school programs, parent-teacher conferences, and school registration days); held 197 "Q&A" chats with individuals seeking services at local Department of Family Resources (DFR) offices, health departments, FQHCs, and other agencies; provided education on HIP at 29 IMPACT community presentations; distributed information on how to apply for HIP after pregnancy to 25 pregnancy support groups and 15 community baby showers; partnered with community centers, food pantries, public libraries, and Covering Kids and Families to educate community members about HIP benefits; worked with School Based Health Centers to promote HIP among uninsured parents; offered presentations on the HIP program to seven Human Resources Departments at companies where insurance was not offered to employees; and conducted various education and health promotion efforts among members. Overall, MDwise staff distributed 200 HIP applications at various community events and presentations, and provided direct assistance to community members on the HIP online enrollment process. MDwise also distributed educational pieces on "How to Stay Enrolled on HHW & HIP," and "Where to Enroll for HHW & HIP" at over 500 community events and presentations.

MDwise publishes a member newsletter, and uses this as a platform to promote and provide education about HIP. It also conducts outreach to members to encourage them to see a doctor within the first 90 days of becoming a HIP member. Further, during 2012, MDwise promoted its "HIP Employer Contribution" inserts to small businesses, disseminated its "Use the Emergency Room Wisely" brochure to members, updated and promoted materials on its Smoke Free program, and disseminated materials on its INControl Disease Management program.

MDwise mails letters to all new members explaining the importance of preventive care and the need to complete the preventive care requirements to realize a full POWER account rollover. MDwise also mails monthly POWER Account invoices and statements that provide a listing of all health care services the member has used in the past year. To assist members during their redetermination period, MDwise sends redetermination reminders and calls members to help them with the process. During the outbound call, MDwise completes a redetermination assessment.

In 2012, MDwise also conducted outreach specifically to providers by offering workshops and/or individual education to all HIP physicians, providing HIP providers with lists of members who had not yet received their required preventive care, publicizing HIP's pay-for-performance opportunities, and participating in multiple provider associations and organizations. In 2010, MDwise piloted its Community Advisory Council program, an initiative involving open forums during which MDwise solicits community and member feedback. MDwise continued this program through 2012, and conducted five Councils in different regions of the state over the course of the year to understand member concerns about health and access to care.

MHS

MHS participated in over 150 member outreach events during 2012, including educational events on nutrition, physical activity, and tobacco use prevention and cessation; community health fairs; healthy lifestyle events at faith-based organizations; health fairs for students and employees at community colleges; events targeting men's and women's health issues; the Indiana Black Expo-Summer Celebration; and the Indiana State Fair. During its Madison County Health Center Diabetic Day/Health Check Health Day, MHS encouraged HIP and HHW members to see their PMP and get the required preventive care. For the event, MHS contacted members whose claims history indicated they were due for one or more recommended preventive services, and invited those members to see their PMP for a check-up and needed screenings.

MHS has also partnered with the Indiana Minority Health Coalition in an effort to help members better understand their POWER accounts and HIP benefits. In addition, it has created a Member Ombudsman Program in partnership with Mental Health America of Indiana to provide personal assistance to members who have difficulty navigating HIP systems. MHS is also currently implementing a program to conduct outreach to HIP members before their redetermination period.

In addition, MHS conducts online marketing. In 2012, the plan posted 65 news items that were approved by the state and published online to educate members and build on the information available in the plan's member handbook and the benefit quick reference guide. The news items covered nutrition, fitness, and general benefit information. For HIP members, these news items included a series of posts called "Quick Tips for HIP," which reminded members about the benefits of receiving preventive care, the meaning of "conditional eligibility," and the importance of making timely POWER account payments. Each news item was posted on the MHS Web site, as well as on Facebook and Twitter.

To help retain members, MHS rewards Member Services staff for accuracy and timeliness in interactions with members.

Enhanced Services Plan (ESP)

The ESP Program (administered by ACS) does not have a formal marketing requirement, but it does have a program to promote preventive care and utilization of lower cost services. The program includes bi-monthly mailings and an annual newsletter that outlines all the preventive care benefits covered by the program, as well as the health consequences of not receiving preventive care.[6] The mailings in 2012 focused on depression, situations when urgent care or discussions with a regular doctor are more appropriate than a trip to the ER, and the importance of getting a flu shot.

Maximus

Maximus, the State's enrollment broker, provides general information and applications for HIP, but continues to focus its efforts, as contracted, on pre-enrollment member information, plan selections, and plan changes.

B. HEALTH PLAN INCENTIVE PROGRAMS FOR MEMBER AND PROVIDERS

Member Incentives

Anthem

In 2012, Anthem introduced a new incentive program to encourage its members to receive preventive services. For this program, Anthem identifies members who are approaching the end of their benefit period without having received the required preventive care, and offers these members a $50 gift card if they secure these services. Mailers were sent to qualifying members encouraging diabetes, breast cancer, and cervical cancer screenings. Breast cancer screening mailers were sent to 2,119 HIP members, 11 percent of whom returned the form to claim the gift card, with a 10 percent return rate for incorrect addresses. Diabetes screening mailers were sent to 1,840 members with 10 percent claiming the reward, and an 9 percent return rate for wrong addresses. Cervical cancer screening mailers were sent to 4,880 members, with 8 percent receiving the incentive and a 7 percent return rate for incorrect addresses. Anthem's 2012 HEDIS results demonstrate the percentage of members who received these preventive services after this campaign, as applicable to their gender and disease state. These rates are comparable to rates in private managed care plans.

Table 5.1: Anthem's 2012 HEDIS Results for Preventive Care Services

Preventive Services	2012 HEDIS Rates	2011 HEDIS Rates
Breast Cancer Screening	58.5%	54.7%
Cervical Cancer Screening	70.2%	65.3%
Diabetes HbAc1	84.5%	86.1%

[6] ESP members are not required to get specific preventive services to obtain a rollover, so there are no financial incentives for them to obtain preventive care as there are for other, non-ESP HIP members.

Anthem also offers incentives for members who complete a Health Risk Assessment (HRA). Those who complete the assessment online or over the phone receive an incentive gift card (with a limit of one per household). In 2012, 9.8 percent of the total HIP Anthem membership earned an incentive gift card as a result of completing the HRA.

MDwise

The MDwise REWARDS program uses incentives to encourage members to seek preventive care. Members earn points for completing an HRA, visiting the doctor for annual exams and health screenings, and registering to receive monthly statements online. Earned points can be redeemed for gift cards. MDwise promoted the incentive program in its main brochure, member handbook, on its Web site, and through postcards mailed to all members. Several of these promotion efforts proved successful in increasing the program's reach. In December of 2012, a mailing was sent to all HIP/HHW households, after which the REWARDS Web site saw a 206 percent increase in unique page views, and there was a 313 percent increase in HIP member gift card redemption. MDwise also created a business card-sized promotional card for providers to hand out to members. After use of the card began, MDwise REWARDS saw a 50 to 100 percent increase in gift card redemptions in the following months.

MHS

MHS has created the CENT-Account Rewards program, through which members receive incentives for various activities. Incentive money is loaded directly onto the member's HIP debit card and can be used to purchase health supplies.. Members can receive a gift card for visiting their assigned PMP within the first 90 days of MHS membership. In 2012, a new incentive was added that pays members a gift card for completing a telephone health risk assessment within the first 90 days of enrollment in the plan.

Provider Incentives

The Indiana Office of Medical Policy and Planning (OMPP) has instituted a Pay for Performance program which utilizes a selection of Healthcare Effectiveness Data and Information Set (HEDIS) measures to track the performance of HIP and HHW providers. In 2011, (the most recent data available at the time of this report—data is reported with almost a two-year delay) the three HEDIS pay-for performance bonus measures pertaining to HIP members were: Follow-up after Hospitalization for Mental Illness; 30-day return rate to the ER; Comprehensive Diabetes Care: LDL Screening. Another pay-for-performance measure was chosen from the CAHPS survey (Consumer Assessment of Healthcare Providers and Systems Survey): the number of smokers advised to quit. There were also two "bonus" measures that pertained to HIP in 2011: Generic Dispensing of Medications rate and Medical Utilization Trend rate.

MDwise and MHS met pay-for-outcomes bonus rates for the Follow-up after Hospitalization for Mental Illness HEDIS measure in 2011. Anthem did not meet pay-for outcomes bonus rates for any of the HEDIS measures pertaining to HIP in 2011; however, Anthem did meet the incentive

rate for the CAHPS measure (smokers advised to quit), whereas MDWise and MHS did not meet the incentive level for this CAHPS measure. All three of the MCE's achieved the bonus rate results for the Generic Dispensing of Medication and the Medical Utilization Trend Rate. It is important to note that this data includes both Hoosier Healthwise and HIP populations and providers.

Anthem and MDwise do not have any additional provider incentives, but MHS continued its Physician Summit Awards in 2012. These awards are given annually to three PMPs. Honorees receive an engraved crystal award and a catered lunch for their staff, and are featured on the MHS Web site and in provider newsletters.

5.2 OPERATIONAL AND POLICY DEVELOPMENTS

A. CONTRACTING

No substantial changes occurred during 2012 MCE contract negotiations; these negotiations focused primarily on rates[7]. In the initial years of the demonstration, the management of plan risk had to be adjusted to account for unforeseen pent-up demand for services, as well as multiple co-morbidities that had been previously untreated. As a result, the State amended the risk-sharing arrangements to include higher monthly capitation rates and a stop-loss provision for non-caretakers (effective retroactively to January 2009), as well as new criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009, January 2010, and May 2011. As of 2011, the plans began reporting declines in utilization and more predictable costs, and the stop loss provision ended with the conclusion of CY2011, though reconciliation with the plans for the prior year continued.

The early high costs of care seen in HIP caused the State to identify ways to broaden access to the ESP, the high risk plan for HIP member with particularly costly conditions. The State expanded the list of qualifying conditions and modified the application process. When HIP applicants check one of the qualifying conditions on the application, they are now automatically enrolled in the ESP and remain enrolled until their eligibility is redetermined. If their claims history at redetermination confirms the information reported on the application, they will stay with the ESP; otherwise, they will be transitioned to one of the other health plans. In addition, the plans have six months to refer a member to the ESP. Those members found to have an ESP qualifying condition and scored at or above 150 points, using underwriting guidelines and a scoring methodology provided by the program's actuary (Milliman) are transferred to the ESP. This process continued through 2012. While the health plans reported that the ESP process ran

[7] The current MCEs were selected through a competitive procurement conducted in 2010. The contracts are for a four year base term with options to extend for an additional two years.

smoothly in most cases, they noted that challenges sometimes emerge when a member does not wish to transfer plans and when lags occur in the State's reconciliation of plan payments.

Calendar year 2012 marked the second year for the HIP and Hoosier Healthwise (HHW) integrated contracts. In 2012, all three of the health plans reported that the combined HIP and HHW contracts allowed for increased administrative ease and for improved care coordination, particularly for families with members enrolled in the two different programs. The plans noted that joint HIP/HHW call centers in particular have improved their ability to serve entire families more effectively. For example, while a call center worker is discussing an issue with a HIP member, the worker now has the ability to view the entire family's record, and can remind the adult if an HHW-enrolled child in the family needs a certain visit or service. In addition, the existence of a single call center enables workers to help families find ways to streamline care. For example, during a call, a member can select a PMP that serves both HHW and HIP members, so that the member and the child can see the same medical provider. Improved outreach was also cited by the plans as a benefit. If a HIP member places a call to the call center, staff will inquire whether the member has a child in the household in need of coverage.

The State has also realized important efficiencies from the integrated contracts, as it has been able to streamline HIP and HHW oversight and monitoring processes. The State has increased its quality review team to four full-time equivalent (FTEs) staff members, and is focused on aligning healthcare quality more closely with contract compliance. The integrated contracts allow both the State and MCEs to increase their focus on quality issues and member behaviors, such as smoking and weight management. Further, the integrated contracts have allowed discussions between the State and MCEs to focus on populations (children and families versus adults), whereas earlier discussions were focused on the differences between the HHW program and the HIP project. From the State's perspective, communication between the State and MCEs has improved as a result.

Calendar year 2012 also marked the second year of the HIP debit swipe cards. The health plans report that throughout 2012, the debit cards functioned primarily as member ID cards. The cards were intended to be used at the point-of-service to verify eligibility, whether the service is covered, and whether the provider is participating in the HIP. The card was also meant to be linked to members' POWER accounts. Anthem and MDwise issue a single-swipe card that functions as the ID and debit card, while MHS issues separate ID and debit cards.

B. MONITORING

Monthly on-site meetings are scheduled between the State and each MCE. These visits follow a uniform protocol so the MCEs know what to expect. In 2012, all three health plans noted their satisfaction with their regular meetings and communications with the State to discuss quality, collaboration, and technical issues. In addition, special working groups were established in 2012 to address specific issues requiring in-depth attention. Working group topics included prior authorization, standardization of forms, timely notice of pregnancy status, and presumptive

eligibility. From this work, the HIP MCE Reporting Manual was revised several times during 2012.

Some issues related to the timeliness with which encounter data were reported by the fiscal agent caused issues for the MCEs as they sought to account for the use of POWER account funds to pay for claims. However, most major issues were resolved by the end of 2012.

In its 2010 External Quality Report (EQR), Burns & Associates noted discrepancies related to how each MCE defines "timeliness" of processing prior authorizations (QR-PA1 reports). A timely review and processing of submitted prior authorizations for services are necessary to ensure that HIP members receive needed services. B & A established that an authorization is considered to have been processed in a timely manner if it processed within seven days for non-urgent pre-service requests, three business days for urgent pre-services requests, one business day after receiving all necessary information on concurrent requests, and 30 days for retrospective requests. The EQR notes that, according to this definition, MDwise processed 99.4 percent of prior authorization requests in a timely manner, approved 97.1 percent of requests, and fully denied 2.6 percent. Anthem processed 99.1 percent of requests in a timely manner, approved 79.1 percent, and fully denied 7.0 percent[8].

The EQR made several recommendations to improve the QR-PA1 reports. First, it recommended that all MCEs utilize the same definition of "number of days to process." Specifically, it noted that MDwise needed to update its methodology to count authorizations resolved on the same day as having taken zero days to process, to align with the other MCE. The EQR also recommended that the State update the service categories to "in-network" and "out-of-network," to reduce reporting problems in this area. To ensure that 100 percent of prior authorizations are reported, the EQR recommended adding a category of "open," "pending," or "modified" authorizations. Other recommendations included encouraging the State to request more information if an MCE reports a denial rate outside the norm, changing the turn-around times by eliminating the "longest number of days to process" statistic, and separately reporting turnaround times for different types of authorizations that are subject to different time restrictions.

In the spring of 2012, the new QR-PA1 reporting process was reviewed in an EQR work group session facilitated by Burns & Associates and the State. Modifications were made to the reporting instructions to clarify guidelines related to the timeliness of prior authorization processing and the in-network and out-of-network delineation. The State believes that these adjustments will improve the alignment of reporting between MCEs.

C. NON-CARETAKER ENROLLMENT

[8] Data is from 2010, when MHS was not involved in HHW/HIP.

To ensure that federal spending does not exceed what would have been spent on Medicaid had HIP not been implemented (budget neutrality), the CMS waiver Special Terms and Conditions (STC) caps the number of childless adults who can enroll in HIP. The initial cap of 34,000 non-caretakers was designated to ensure HIP remains budget neutral for the Federal government. On March 12, 2009, HIP closed enrollment to non-caretakers. At that time, the number of non-caretaker members had reached 32,000, just below the 34,000 cap established in the STCs. Enrollment for non-caretakers was closed before the cap was reached to ensure that applicants in the eligibility determination process or appealing denied applications could be enrolled without exceeding the cap. At the same time, all new applications from non-caretakers were reviewed for eligibility and placed on a waiting list if determined eligible.

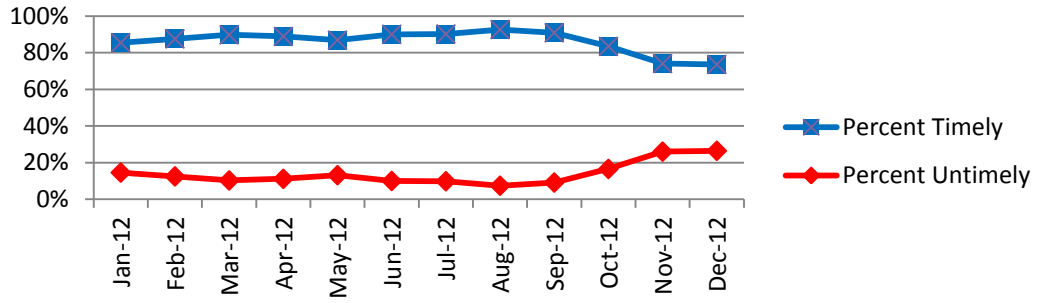
Since closing enrollment to non-caretakers in March 2009, enrollment has been opened three times to this group, once in November 2009 when CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers and again in August 2011. The first open enrollment period resulted in 1,087 new non-caretakers entering the HIP program between January and March 2010. The second open enrollment period resulted in 2,157 new non-caretakers by the end of 2011.

During the first quarter of the 2012 calendar year, 18,800 letters were sent to non-caretakers on the waitlist, inviting them to reapply for the program. In response to these letters, 1,587 individuals responded and were able to enroll (generating an 8.4 percent response rate), and 7,113 additional individuals were added to the waitlist. The rest of the letters generated no response, indicating that potential applicants' financial or living situations had changed, or they were no longer living at the address on record. The waitlist was closed as of April 2012 (no additional individuals were added between April and December) as the State waited for guidance from CMS on whether HIP could be used for the Medicaid expansion under the Affordable Care Act of 2010.

D. APPLICATION PROCESSING

Throughout the first nine months of 2012, application processing timeliness rates hovered between 85 and 90 percent, reaching 92.6 percent in August (Figure 5.1). In September, the timeliness rate started to decline, and during November and December approximately 25 percent of applications were not processed in a timely manner. Averaging across all months, 86.4% of applications were processed in a timely manner in 2012. The HIP application processing timeliness standard is 45 days.

Figure 5.1 Percentage of Pending Applications Processed in a Timely Manner, January-December 2012



Source: ICES Eligibility System, January 2012-December 2012

E. HIP AMENDMENTS APPROVED BY CMS

The State did not submit any amendments for the HIP program in 2012. In September 2012, CMS granted a one-year extension of HIP, in response to a waiver extension submitted in December 2011. In February 2013 the State submitted a request to extend the program beyond 2013 for the maximum waiver renewal period of 3 years. In response, CMS granted another one year extension which permits the program to operate through December 31, 2014.

5.3 FINANCIAL AND BUDGET NEUTRALITY

The State maintained waiver margins well below the CMS-approved limit from DY1 through DY4 by negotiating actuarially sound rate increases. This allowed the state to request the restoration of the Disproportionate Share Hospital funding. The cumulative cost of the HIP program from 2008-2012 was just over $1 billion, with an additional $12-$15 million in administrative costs annually[9]. In DY5 the waiver margin was negative due to increased hospital reimbursement rates authorized by Public Law 229-2011, Section 281 (described in more detail in Section 6.7). These increased rates led to higher Per Member Per Month (PMPM) expenditures for HHW caretakers, children, and pregnant women in 2012. PMPM expenditures for HIP caretakers and non-caretakers in DY5 aligned closely with DY4 expenditures for these groups. However, as the waiver margin is cumulative, HIP remained budget-neutral over the first five years of the demonstration.

5.4 CONSUMER ISSUES

[9] Source: Milliman Budget Neutrality Waiver Renewal Report to the Family and Social Services Administration, July 2013.

The State maintains a consumer issue management system known as the "Internet Quorum" or "IQ," which permits the State to monitor and manage formal and informal inquiries. Overall, the number of consumer inquires posed through the IQ has declined over the five years of the program, which could be correlated with the decrease in enrollment. Most questions posed in 2012 were classified as requesting "general information" on the program; other questions most commonly asked were regarding the HIP buy-in option.

Table 5.2 Internet Quorum Inquiries, 2008 - 2012

Quarter	Total Number of Inquiries					Change
	2008	2009	2010	2011	2012	
Year Total	1,695	1,205	693	575	364	-79%
First	628	425	270	152	133	-79%
Second	486	289	206	123	100	-79%
Third	278	261	128	164	95	-66%
Fourth	303	230	89	136	36	-88%

Source: HIP Quarterly Report to CMS, 2008 - 2012

Table 5.3 Types of Inquiries, 2012

Issue	Percentage of Inquiries on that Issue
General Questions	63%
Buy-in	18%
Waiting List	6%
Anthem	6%
ESP	1%
MDwise	4%
MHS	2%

Source: HIP Quarterly Reports to CMS, 2012

The State also tracks the number of eligibility appeal hearings each year. These appeals involve issues such as benefit terminations. Member appeals may also involve the required amount of POWER account contributions. The annual number of member appeals peaked in 2010, when total HIP enrollment also peaked.

Table 5.4 Formal Appeal Hearings, 2008 – 2012

Quarter	Total Number of Formal Appeal Hearings				
	2008	2009	2010	2011	2012
Year Total	1,003	2,223	6,118	5,391	5,783
First	181	263	1,422	1,182	1,503
Second	336	1,249	1,584	1,083	1,529
Third	286	586	1,721	1,690	1,394
Fourth	200	125	1,391	1,436	1,357

Source: HIP Quarterly Reports to CMS, 2008 – 2012

Table 5.5 Adjudication of Appeals and Hearings, 2009 – 2012

Findings	Percentage of Hearings and Appeals			
	2009	2010	2011	2012
Other Insurance	60%	44%	46%	30.47%
Did Not Complete Verifications Request from State	21%	26%	43%	59.7%
Other	10%	25%	0.2%	0.2%
Financial Eligibility	8%	5%	10%	9.4%

Source: HIP Quarterly Reports to CMS, 2009- 2012

5.5 ELIGIBILITY AND ENROLLMENT INFORMATION

A. DY5 HIP ENROLLMENT DEMOGRAPHICS

The State's analysis of HIP enrollment records indicates that HIP served a total of 56,245 unique individuals during 2012. The majority of 2012 members were female, and those in the 30 to 39 age group made up the greatest proportion of HIP members. Very few members were under 20 or above 60. Due to the program's cap and waitlist for non-caretakers, more than two-thirds of members in 2012 were caretakers. Over 80 percent of members were white, and African-Americans comprised approximately 10 percent of the HIP membership. These figures align closely with state demographic data—86.6 percent of Indiana's population in 2012 was white, and 9.4 percent was African-American. The majority of 2012 HIP members (70 percent) had incomes at or below the federal poverty level (FPL).

The DY 5 membership demographics are consistent with the cumulative demographic data for all members over the course of the HIP program (2008-2010). Between 2008 and 2012, women made up the majority of the membership (67.6 percent), and those in the 30-39 age range comprised the greatest share of beneficiaries. The 2008-2012 cumulative racial and ethnic breakdown is similar to that of 2012—African-Americans comprised approximately 12 percent of the total membership during this timeframe, and over 80 percent of members were white. Between 2008 and 2012, 70 percent of members had incomes at or below 100 percent of the FPL.

Table 5.6. Enrollment Demographics, DY5 (2012)

Characteristic	Number of Members in 2012	Percentage of Total
Total number	56,245	100.0
Gender		
Female	38,030	67.6%
Male	18,215	32.4%
Age		
<20	21	< 0.1%
20-29	7,680	13.7%

Characteristic	Number of Members in 2012	Percentage of Total
30-39	17,251	30.7%
40-49	16,407	29.2%
50-59	11,130	19.8%
60+	3,756	6.7%
Caretaker Status		
Caretaker	38,740	68.9%
Non-caretaker	17,505	31.1%
Race/Ethnicity		
Asian	1,159	2.1%
Black	5,895	10.5%
Hispanic	1,927	3.3%
American Indian	45	0.1%
Other	1,083	1.9%
White	46,136	82.0%
Income as a Percentage of FPL		
<22%	15,570	27.7%
23%-50%	6,780	12.1%
51%-100%	17,145	30.4%
100%-150%	11,123	19.8%
>150%	5,627	10%

Source: OMPP Data Management & Analysis

B. IMPACT ON THE STATE'S UNINSURANCE RATE

HIP was designed to serve a limited number of Hoosiers, and the Indiana General Assembly cigarette tax increase does not generate sufficient revenue to cover all adult Hoosiers under 200 percent of FPL. Crowd-out provisions, such as the requirements to be uninsured for six months and having no access to employer-sponsored health insurance, also limit the number of individuals who are eligible. According to Current Population Survey (CPS) estimates, individuals with income under 100 percent of the FPL had the highest uninsurance rate in the years before HIP was implemented, ranging from 47 percent among the most low-income group to 41 percent for those with incomes just below the poverty level (Table 5.7).[10]

Using data from the American Community Survey (ACS) from 2008-2011, Milliman estimates that the number of uninsured adult Hoosiers with incomes below 200 percent of FPL (Table 5.7) grew from the pre-HIP period and continued to increase over the four-year period, likely due in part to the national recession occurring during this time period. However, these trends mask the variation that occurs at different income levels. The uninsured rate for Hoosiers with incomes under 50 percent of FPL has *decreased* from about 47 percent in 2005-2007 and held steady at

[10] The data for individuals with incomes less than 51 percent of poverty were aggregated because the CPS does not separate estimates for incomes less than 22 percent of poverty or between 23 and 50 percent of poverty.

approximately 43 percent between 2008 and 2012. Uninsured rates for other income groups have increased since before HIP was implemented. The increase in the uninsurance rate among income groups above 50 percent of the FPL is likely due to external factors such as the national economic recession and high unemployment rates during the HIP implementation period.

Table 5.7. Uninsured Rates, by FPL before and after HIP

	Uninsured Adults Ages 19-64 before HIP (CPS 2005-2007)		Uninsured Adults Ages 19-64 (ACS 2008)		Uninsured Adults Ages 19-64 (ACS 2009)		Uninsured Adults Ages 19-64 (ACS 2010)		Uninsured Adults Ages 19-64 (ACS 2011)		HIP Members Ever Enrolled in 2012
FPL Level	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Under 50% FPL	85,977	47.2%	88,974	43.3%	95,878	40.1%	115,308	43.1%	121,959	43.1%	20,862
51% - 100% FPL	80,063	40.8%	103,102	42.3%	111,258	40.7%	124,712	44.2%	121,812	43.5%	11,329
101% - 150% FPL	89,426	34.8%	113,782	41.7%	115,394	39.1%	127,031	37.8%	133,837	41.0%	17,818
151% - 200% FPL	79,497	26.5%	86,535	28.4%	108,586	33.2%	115,320	32.9%	108,075	31.9%	6,236
Total	***334,963***	***35.8%***	***392,393***	***38.22%***	***431,116***	***37.97%***	***482,371***	***39.03%***	***485,683***	***39.28%***	***56,245***

Source: Milliman, Inc. "Uninsured rates by FPL and year." November 16, 2012. Baseline uninsured numbers and percents are from the U.S. Census Bureau, CPS, Annual Social and Economic Supplement, 2006-2008, CPS three-year average data collected 2006-2008 reporting on the prior year (2005-2007). http://www.census.gov/hhes/www/cpstc/_cps_table_creator.htm. Accessed March 10 2011. HIP enrollment numbers supplied by the State of Indiana.

Note: 2012 ACS data were unavailable at the time this report was written.

There is also some variation in the uninsurance trends with respect to gender and age. During the time of HIP implementation, uninsured rates among men increased more than those among women. At the same time, the Medicaid coverage rate among women increased 3 percent from 2008 to 2011, as compared to 2.3 percent for men. Uninsured rates also varied by age. While those in the 19-29 age group saw a drop in uninsured rates, older groups saw an increase. The 50-64 age group experienced a 5.1 percentage point increase in the uninsurance rate from 2008 to 2011. The uninsurance rate among caretakers dropped 1 percentage point during this time period, while the Medicaid coverage rate among the same group rose 6.3 percentage points. Nevertheless, the uninsurance rate among non-caretakers is most likely to be affected by the HIP program, because these individuals can only access Medicaid if they are disabled. Statewide non-caretaker uninsured rates rose by 1.8 percentage points, while Medicaid coverage among non-caretakers increased by 1.7 percentduring this time. Presumably, the uninsured rates for these groups would have been higher had Medicaid, and possibly HIP, not been available. The ACS data do not allow a more detailed analysis of whether these non-caretakers were obtaining coverage through HIP or Medicaid's provision for people with disabilities, but some proportion would have been uninsured during this period had the HIP program not been available to them.

See Table 5.8.

Table 5.8: Proportion of Indiana's Low-Income Working-Age Adults (19 through 64) Who Are Uninsured, 2008-2011

Subgroup	Statewide Uninsured Rates					Statewide Medicaid Coverage Rates				
	2008	2009	2010	2011	Percentage Point Change	2008	2009	2010	2011	Percentage Point Change
Total	38.2%	38.2%	39.2%	39.5%	1.3	18.0%	20.7%	19.6%	20.6%	2.6
Males	41.3%	42.9%	43.8%	43.5%	2.2	13.8%	15.6%	15.4%	16.1%	2.3
Females	35.6%	34.3%	35.3%	36.0%	0.4	21.6%	25.2%	23.3%	24.6%	3.0
Ages 19-29	42.5%	41.9%	43.4%	40.6%	-2.0	15.6%	18.6%	16.7%	17.1%	1.5
Ages 30-49	40.0%	39.3%	39.9%	42.2%	2.2	17.5%	20.6%	19.9%	21.2%	3.7
Ages 50-64	28.4%	30.3%	31.8%	33.5%	5.1	22.5%	24.5%	23.2%	24.6%	2.1
Caretakers	34.3%	30.3%	33.1%	33.3%	-1.0	22.1%	29.2%	25.7%	28.4%	6.3
Non-Caretakers	39.5%	40.9%	41.1%	41.3%	1.8	16.7%	17.9%	17.7%	18.4%	1.7

Source: Mathematica analysis of 2008-2011 ACS data.

C. AUTO-ASSIGNMENTS AND REASSIGNMENTS

Three-fourths of individuals enrolling in HIP for the first time in 2012 selected their plan of choice at the time of application, while 22 percent were auto-assigned to a plan. Twenty percent were auto-assigned to one of the health plans—Anthem, MDWise, or MHS, and two percent to the ESP program. Approximately three percent received assistance from an enrollment broker (Table 5.9). A majority of new members for Anthem and MDwise selected their plans at enrollment, while most of MHS' new members were auto-assigned to their plan.

The total number of new members in 2012 was comparable to 2011 totals (with 13,284 new members in 2012 and 12,980 in 2011), and all plans saw an increase in new members. Anthem gained 66 percent of the new members, MDwise, 10 percent of the new members, and MHS 22 percent of the new members. However, the distribution of new members across plans changed in DY5. MDwise gained 61 percent fewer new members in 2011 than in 2012. These new members either selected, or were auto-assigned, to Anthem and MHS. (Because MHS was new in 2011, enrollees in the service area were auto-enrolled if they did not select a plan on their own).

The number of individuals assisted by an enrollment broker dropped between 2011 and 2012. While 734 new members selected a plan with the assistance of a broker in 2011, only 428 received this type of assistance in 2012, a 42 percent decrease.

Table 5.9. Health Plan Assignment Methods, Initial Assignments for Those Enrolling in HIP for the First Time in 2012

Form of Plan Selection	Anthem	ESP	MDwise	MHS	Total Number
	%	%	%	%	%
Total	8,808	209	1,299	2,968	13,284
	66.3%	1.6%	9.8%	22.3%	100.0%
Assigned to ESP	1	208	0	0	209
	0.0%	99.5%	0.0%	0.0%	1.6%
Auto-Assigned	559	1	195	1,982	2,737
	6.4%	0.5%	15.0%	66.8%	20.6%
Enrollment Broker Assisted	309	0	72	47	428
	3.5%	0.0%	5.5%	1.6%	3.2%
Member Selection on Application	7,939	0	1,032	939	9,910
	90.1%	0.0%	79.5%	31.6%	74.6%

Source: OMPP Data Management & Analysis

D. HEALTH PLAN CHANGES

Upon enrollment in the HIP, members select or are assigned to one of the three health plans, unless answers to the Health Screening Questionnaire portion of the HIP application indicate that assignment to the ESP is appropriate. Once enrolled, members may change their plan selection before making their first POWER account contribution (or afterwards, for cause, as discussed below). After receiving notice of a new member's conditional eligibility, the health plan sends a "welcome letter" notifying the member that the first POWER account contribution will be due within 60 days of the conditional eligibility date. Members *not* in the ESP may change health plans without cause within this 60-day window, before they make their first POWER account contribution. After the first POWER account contribution is made, members cannot change plans without filing a grievance with the MCE or unless they move out of the MCE's service area.[11] Members may also change plans when their eligibility for the program is redetermined (at annual renewal).

During the first three years of program operations, a total of 2,475 plan changes occurred, out of almost 60,000 enrolled members. In 2008, 520 changes occurred, 837 changes occurred in 2009, and 1,118 changes happened in 2010. The number of plan changes increased in 2011 and 2012, as an additional MCE was added and enrollment grew (Table 5.10).

Table 5.10 Health Plan Changes in the HIP by Year, 2008-2012

[11] A member may request to change health plans for cause at any time after exhausting the plan's internal grievance and appeals process.

Type of Change	2008		2009		2010		2011		2012	
	Number of Plan Changes	%	Number of Plan Changes	%	Number of Plan Changes	%	Number of Plan Changes	%	Number of Plan Changes	%
Total Number of Plan Changes	520	100%	837	100%	1,118	100%	2,988	100%	1,941	100%
Anthem →MDwise	9	2%	225	27%	137	12%	274	9.2%	231	11.9%
Anthem → MHS	-	-	-	-	-	-	97	3.2%	83	4.3%
Anthem → ESP	40	8%	67	8%	268	24%	552	18.5%	482	24.8%
MDwise →Anthem	12	2%	236	28%	128	11%	913	30.6%	254	13.1%
MDwise → MHS	-	-	-	-	-	-	459	15.4%	53	2.7%
MDwise →ESP	18	3%	73	9%	478	43%	275	9.2%	249	12.8%
MHS → Anthem	-	-	-	-	-	-	211	7.1%	293	15.1%
MHS → MDWise	-	-	-	-	-	-	80	2.7%	108	5.6%
MHS → ESP	-	-	-	-	-	-	4	0.1%	19	1%
ESP → Anthem	301	58%	125	15%	70	6%	54	1.8%	82	4.2%
ESP → MDwise	140	27%	111	13%	37	3%	67	2.2%	66	3.4%
ESP → MHS	-	-	-	-	-	-	2	0.1%	21	1.1%

Source: OMPP Data Management & Analysis, via HP and Maximus

Table 5.11 Month of Enrollment when Health Plan Change occurred, for those who changed health plans, by year, 2011 and 2012

	2011	2012
Percent who switch in month 1	8.5%	11.2%
Percent who switch in month 2	3.3%	4.4%
Percent who switch in months 3	3.1%	3.8%
Percent who switch in month 4-12	27.2%	41.2%
Percent who switch in month 13 +	57.9%	39.4%

Source: OMPP Data Management & Analysis, via HP

5.6 POWER ACCOUNTS

A. POWER ACCOUNT CONTRIBUTIONS

The POWER account is a key feature of the Healthy Indiana Plan. Instead of traditional cost-sharing of premiums and copayments, HIP participants make upfront contributions for their health care through required POWER account contributions. The funds contributed to the POWER account are used to pay for deductible expenses ($1,100 annually). Contributions are based on a sliding scale tied to income so that individuals can afford to make the monthly payments but still have "skin in the game." The program ensures that no participant pays more than 5% of his or her income to the POWER account, consistent with CMS rules. The State then subsidizes the POWER account to ensure that it is fully funded, up to the amount of the deductible. Employers are also currently allowed to make up to 50% of the member's required contribution.

Participants have control over how POWER account dollars are spent and receive monthly statements on POWER account expenditures and account balances. Unlike traditional premiums or copayments, HIP members own their contributions and are entitled to any unused contributions if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by the program allowing any remaining POWER account balance after 18 months of enrollment— including the portion that is the State's contribution—to roll over and offset required contributions in the next year. If individuals do not complete the required preventive services, only the pro-rated balance of their individual contribution rolls over. The incentive is designed to increase the use of preventive care. Because the health plans wait six months after the member's benefit period ends for claims to run out, they do not calculate rollovers until members have been enrolled for 18 months to assure that all services have been reimbursed.

While every HIP member has a POWER account, members make different monthly contributions based on a sliding scale tied to income. Contributions vary from 2 to 5 percent of household income. In 2012, 77 percent of HIP members were required to make some contribution to their POWER accounts. Those in the lowest income bracket – 22 percent of the FPL or below – make the lowest average monthly contribution, $7.94 each month (Table 5.12). The amount of the required payments rise as income increases, with individuals with incomes between 150 and 200 percent of the FPL ($15,756-$23,340) required to make average monthly payments of $61.01, but not more than $93.08.

Table 5.12 Average POWER Account Monthly Payment in 2012, by FPL

FPL	Estimated Income for an Individual	Average Monthly Contribution for HIP Members
<22%	$0 - $11,170	$7.94
23%-50%	$11,171 - $13,963	$10.32
51%-100%	$13,964 - $15,083	$17.77

FPL	Estimated Income for an Individual	Average Monthly Contribution for HIP Members
100%-150%	$15,084 - $16,755	$39.69
>150%	$16,756 - $23,340	$61.01

Source: OMPP Data Management & Analysis

Approximately twenty-three percent of HIP members were *not* required to make monthly contributions to their POWER accounts in 2012 (Table 5.13). These individuals do not make contributions either because they have no income, or because the family is already spending five percent of its income on premiums and cost-sharing requirements for family members covered by Medicaid or the State Children's Health Insurance Program. Those in the non-contributor group tend to report much lower incomes than the HIP population as a whole. See Table 5.13.

Table 5.13. Demographic Characteristics of HIP Members Not Required to Make Monthly POWER Account Contributions, 2012

Characteristics	All HIP Members in 2012		HIP Members with No Monthly Contributions	
	Number	Percentage of Total	Number	Percentage of Total
Total number	56,245	100.0%	12,688	22.6%
Gender				
Female	38,030	67.6%	7,586	59.8%
Male	18,215	32.4%	5,102	40.2%
Caretaker Status				
Caretaker	38,740	68.9%	6,042	47.6%
Non-caretaker	17,505	31.1%	6,646	52.4%
FPL				
<22%	15,570	27.7%	10,470	82.5%
23%-50%	6,780	12.1%	417	3.3%
51%-100%	17,145	30.4%	447	3.5%
100%-150%	11,123	19.8%	1,136	9.0 %
>150%	5,627	10%	218	1.7%

Source: OMPP Data Management & Analysis

Each year, the majority of HIP members who were involved in the POWER account rollover process did not have an account balance left after 18 months of enrollment. This is a reflection of the high prevalence of chronic disease among the HIP population, as discussed further in Section 6.5. A Milliman analysis of 2012 claims showed that among those enrolled in HIP for at least six months during 2012, 32 percent of members had cardiovascular disease, 24 percent had a psychiatric diagnosis, 20 percent had a skeletal and connective tissue disease, 19 percent had a gastrointestinal ailment, and 13 percent had diabetes. Multiple diagnoses were common as

well—approximately 30 percent of HIP members had been diagnosed with three or more chronic conditions in 2012. These members incur higher healthcare costs to manage and treat their chronic disease(s), and therefore tend to quickly meet the deductible and exhaust the POWER account. By the end of 2012, just over one-third of POWER accounts eligible for a rollover over the course of the demonstration contained any funds to carry forward. Similar data has been previously reported at the end of 2009 and 2010; however, the rates discussed here reflect updated data sets from the MCE's in which all member account reconciliations have been included. This data is cumulative, reported on a rolling basis as of the end of each calendar year.

Table 5.14 POWER Account Rollover Reconciliation

Status	2009	2010	2011	2012
Percent of accounts with a balance after 18 months of member enrollment	36.1%	35.2%	34.7%	34.6%
Of those accounts, percent that received a partial rollover (did not receive recommended care)	44.7%	58.9%	64.9%	65.2%
Of those accounts, percent that received a full rollover (received recommended preventive care)	55.3%	41.1%	35.1%	34.8%

Source: MCE POWER Account Reconciliation Files

Of those accounts that did have a balance, the majority received a partial rollover, meaning just member contributions were rolled over. Members who do not spend down their POWER accounts and retain a balance at the end of 18 months are likely to be healthier, have a lower rate of chronic disease, and use fewer healthcare services (totaling less than $1,100 annually) than those who do exhaust their funds. Since overall preventive care utilization rates are much higher in the general HIP population, the observed lower rate among those with funds remaining in the POWER account might be due to a perception of lower need for routine physicals and screenings and lower health service utilization in general. The MCEs continue to work to promote the preventive care incentive and develop member awareness and understanding of how the POWER account works.

B. COST-SHARING LIMIT MONITORING

Per CMS rules for HIP caretakers, the total aggregate amount of (1) POWER account contributions, (2) HIP Emergency Room copayments, (3) Medicaid cost sharing requirements, and (4) CHIP cost sharing requirements may not exceed five percent of family income. The health plan verifies the member's cost-sharing documentation, and then notifies the HIP program manager that the member has reached the five percent maximum contribution amount and the date it occurred. Then the member is not required to pay any further POWER account contributions or ER co-payments for the rest of the 12-month benefit period. Member handbooks

were modified in 2009 to clarify that members must maintain their receipts and document their out-of-pocket costs.

C. COST-SHARING-POWER ACCOUNT CONTRIBUTION RATES

After completing an application and meeting the financial and other eligibility criteria, members are "conditionally eligible" for the HIP program. They do not become fully eligible until they make their first POWER account contribution. Individuals with no required POWER account contribution, however, become eligible immediately after they meet the financial and other criteria. (Individuals with no required contributions either have no income, or are exempt due to CMS cost-sharing rules). Once fully enrolled, members must continue to make monthly contributions to maintain their HIP eligibility. If they fail to do so within the grace period, they are disenrolled, and must wait 12 months to re-apply. The State has collected annual data on the rates at which HIP members make required contributions to the POWER account. The rate of members who make their initial contributions to complete the enrollment process has increased consistently each year of the demonstration. The rate of members who continue to make subsequent required monthly contributions has decreased slightly, but continues to stay well under 10 percent.

Over the demonstration period, the State has refined both the quality of the data as well as the methods of accessing the records used to assess rates of member contribution over the course of the demonstration. In the past, if members were missing data in any fields of their eligibility file, they were excluded from analysis. The State has developed mechanisms to correct this, leading to inclusion of more members in the analysis and more robust reporting. The new methodology has been applied retroactively and the data below represents an updated annual review of contribution rates.

The HIP program has historically had low non-contribution rates, suggesting that the disenrollment penalty could be a strong motivating factor to make regular payments. Data from the 2013 Mathematica survey also supports that the required financial contributions are affordable and HIP participants prefer making upfront contributions rather than making copays. According to the survey, 85 percent of HIP enrollees believed that their required contributions were either the right amount or below the right amount. In 2012, 94.2 percent (52,996) of HIP members made the initial POWER account contribution if required and only 5.8 percent (3,249 individuals) did not. Although there is some variation between income brackets, the majority of individuals at all levels made the first required POWER account contribution.

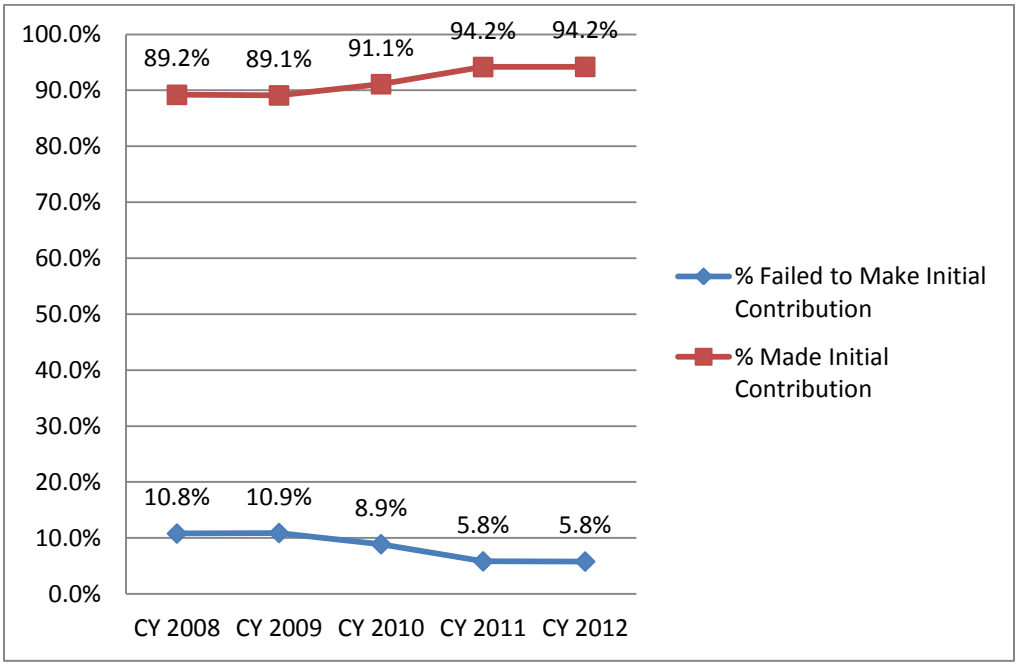
Table 5.15. Calendar Year 2012 Initial Non-Contribution Rates (Did Not Make First POWER Account Contribution)

FPL Level	Number Who Never Made First Contribution	Total Members	Initial Non-Contribution Rate
<22%	522	15,570	3.4%
23%-50%	401	6,780	5.9%
51%-100%	1,445	17,145	8.5%
101%-150%	641	11,123	6.1%
>150%	240	5,627	4.3%
Total	**3,249**	**56,245**	**5.8%**

Source: OMPP Data Management & Analysis
Note: Almost one quarter (13,293) of total 2012 enrollees (56,245) were exempt from making POWER account contributions.

Initial contribution rates have increased consistently over the course of the HIP demonstration. In DY 1 (CY 2008), the initial non-contribution rate among HIP enrollees was about 10.8 percent. This rate dropped over five years; reaching 5.8 percent in in 2011 and staying steady in 2012 (see Figure 5.2). These figures include members not required to make contributions in the calculations.

Figure 5.2. Initial POWER Account Contribution and Non-Contribution Rates, CY 2008-2012



Source: MedInsight, HP

In 2012, 93 percent of HIP members continued to make their required monthly contributions to remain enrolled in the program. Another 3,924 HIP members (about 7 percent) failed to make a required monthly contribution and were disenrolled (Table 5.16). Subsequent non-contribution rates were similar across all income brackets—highest at the 51-100 percent FPL bracket, and lowest at the <22 percent FPL income bracket. These figures include members not required to make contributions in the calculations.

Table 5.16. Calendar Year 2012 Subsequent Non-Contribution Rates

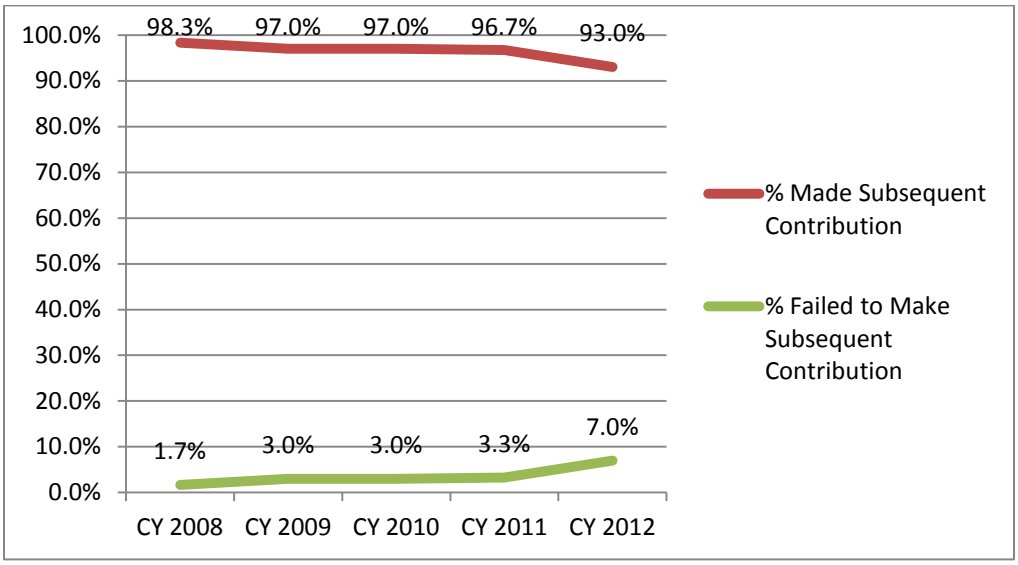
FPL Level	Number Who Missed a Subsequent Monthly Contribution	Total Members	Subsequent Non-Contribution Rate
<22%	333	15,570	2.1%
23%-50%	606	6,780	8.9%
51%-100%	1,616	17,145	9.4%
100%-150%	961	11,123	8.6%
>150%	408	5,627	7.3%
TOTAL	**3,924**	**56,245**	**7.0%**

Source: OMPP Data Management & Analysis

Note: Almost one quarter (13,293) of total 2012 enrollees (56,245) were exempt from making POWER account contributions.

Annual subsequent non-contribution rates rose slightly during the demonstration. In DY 1 (CY 2008), the subsequent non-contribution rate was very low, 1.7 percent (see Figure 5.3). It rose slightly to 3 percent in 2009 and hovered around the same rate for three years. In CY 2012, the subsequent non-contribution rate rose again, perhaps due to reasons unrelated to cost such as uncertainty surrounding the future of the program or gaining other insurance. For the first four years of the program, subsequent non-contribution rates were lower than initial non-contribution rates, suggesting that once members are fully enrolled, they tend to remain in the program and that contribution amounts are affordable.

Figure 5.3. Subsequent POWER Account Contribution and Non-Contribution Rates, CY 2008-2012



Source: MedInsight, HP

Failure to make an initial POWER account payment was also not one of the top five reasons for HIP enrollment denials in 2012 (Table 5.17), which is consistent with earlier years (Table 5.18).

Table 5.17. Top Five Types of HIP Denials in Calendar Year 2012

Member Count	Denial Reason
43,105	Non-Caretaker cap reached
18,172	Did not verify income
11,100	Failure to provide insurance information
8,603	No proof of citizenship
4,420	Employer offers health insurance

Source: OMPP Data Management & Analysis

Table 5.18. Top Five Types of HIP Denials in Calendar Years 2008-2012

Member Count	Denial Reason
191,053	Non-Caretaker cap reached
73,179	Did not verify income
38,170	Failure to provide insurance information
37,268	No proof of citizenship
26,466	Employer offers health insurance

Source: OMPP Data Management & Analysis

Failure to make a subsequent POWER account payment was the second most common reason for dis-enrollment in 2012 (Table 5.19). Other top reasons included a failure to return the HIP renewal packet, the presence of other health insurance, a failure to verify income, or closure due to an appeals ruling. This is consistent with earlier years.

Table 5.19. Top Five Types of HIP Member Accounts Closed in Calendar Year 2012

Member Count[12]	Denial Reason
4,415	HIP packet not returned
3,924	Failure to make POWER account payment
2,658	Closed due to appeals ruling
1,805	Other current health insurance
1,085	Did not verify income

Source: OMPP Data Management & Analysis

Table 5.20. Top Five Types of HIP Member Accounts Closed in Calendar Years 2008-2012

Member Count[13]	Denial Reason
22,643	HIP packet not returned
12,490	Failure to make POWER account payment
7,724	Other current health insurance
5,293	Closed due to appeals ruling
5,165	Medicare Part A or B currently.

Source: OMPP Data Management & Analysis

Coverage and Benefit Limits

HIP benefits are limited to $300,000 annually and $1 million lifetime. The health plans and the State identify members when they reach $200,000 in annual benefits. The health plans and the State closely monitor these members, and work to refer them appropriately to other programs, including Medicaid and M.E.D. Works (Indiana‘s Medicaid Buy-In program for those with disabilities). For the calendar year 2012, no HIP member had reached the lifetime benefit maximum.

[12] Total unique enrollment in 2012: 56,245 members. Therefore, 25 percent of members disenrolled for some reason in 2012.

[13] Total unique enrollment across all five years: 105,197. Therefore, over 5 years, 50.7% of those who have enrolled have disenrolled for some reason.

Table 5.21. Number of HIP Members Who Reached $200,000 in Annual Benefits During 2012

	Anthem	MDwise	MHS	Total
Total Number	0	2	0	2

Source: HIP Quarterly Reports to CMS, 2012

Table 5.22. Number of HIP Members Who Reached $300,000/Annual or $1,000,000/Lifetime in Benefits During 2012

	Anthem	MDwise	MHS	Total
Total Number	0	0	0	0

Source: HIP Quarterly Reports to CMS, 2012

SECTION 6: EVALUATION FINDINGS TO DATE

In March 2009, Mathematica Policy Research was selected as the evaluation contractor for HIP. This section represents the analyses Mathematica has completed for the fifth year of the demonstration program (calendar year 2012). Results of the second telephone survey of HIP members undertaken since the HIP demonstration began are also presented. This survey, completed in the spring of 2013, included a sample of 847 current HIP enrollees, along with 620 individuals who had been previously enrolled in HIP within 12 months of the survey.

6.1 GOAL I – REDUCE THE NUMBER OF UNINSURED LOW-INCOME HOOSIERS

HIP seeks to reduce the number of uninsured low-income Hoosiers by providing an insurance option for those who do not have access to employer-based coverage and do not currently qualify for other public insurance. While 2012 ACS data on uninsurance rates are unavailable at the time of writing, uninsured rates for individuals aged 19 to 64 and below 200 percent of the FPL remained relatively constant through the first four years of the demonstration. Two factors may have impeded the program's ability to reduce the number of uninsured low-income Hoosiers. First, the program was implemented during a significant economic downturn when the uninsured rate was increasing. Second, the program limits enrollment of non-caretaker adults by design to meet its budget neutrality requirements.

After five years, HIP has served 105,197 Hoosiers. Major findings on HIP enrollment include:

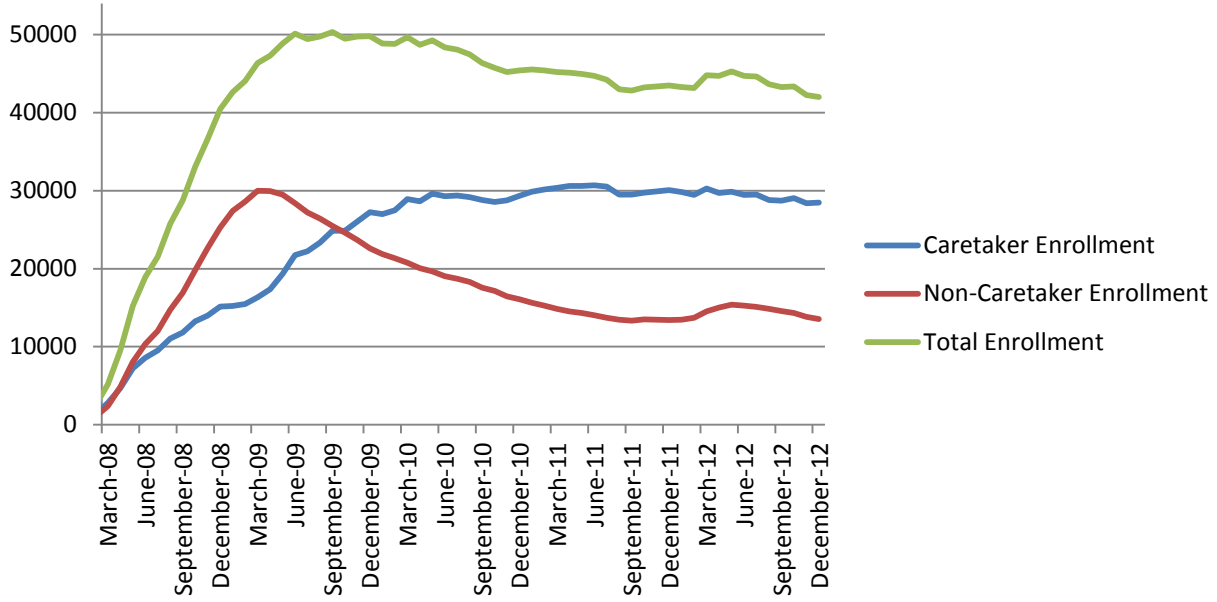
- As reported in previous demonstration years, monthly enrollment grew steadily from the program's inception until April 2009, when it began to level off with about 46,000 to 47,000 enrollees per month. Enrollment figures approached the non-caretaker adult cap in early 2009 and the State closed enrollment to non-caretakers at that time. Monthly enrollment remained relatively stable until September 2010, when it fell into the 43,000-44,000 range. The State opened the non-caretaker waiting list in 2010 and again in 2011. By December 2011, enrollment numbers had dropped. As of December 31, 2012, 39,005 individuals were enrolled in the program. At this time, an additional 3,005 Hoosiers were conditionally enrolled (had been determined eligible, but had not yet made the required initial POWER account contribution), for a total of 42,010 individuals.
- The program continues to enroll more women than men (38,030 women vs. 18,215 men enrolled during 2012), and more caretakers than non-caretakers (38,740 caretakers vs. 17,505 non-caretakers during 2012). However, non-caretakers comprised a greater proportion of the total HIP population until about September 2009, about six months after the non-caretaker cap was reached and the waitlist was implemented.

A. ENROLLMENT TRENDS IN HIP

Overall monthly enrollment in HIP increased steadily from the program's inception in January 2008 through mid-2009 (Figure 6.1). Non-caretakers enrolled at a much higher rate than caretakers through April of 2009, when non-caretaker adults found to be eligible were placed on

a waiting list. Enrollment of this group steadily decreased through October 2011. In February of 2012, the number of non-caretaker enrollees began to increase and continued to rise until June, when numbers began to decrease again. By December 2012, the total number of enrolled non-caretakers had returned to levels seen at the beginning of 2012. Caretaker enrollment increased steadily from the beginning of the program through July of 2010, when it began to level off. Caretaker enrollment remained relatively steady through 2012, dropping slightly toward the end of the year.

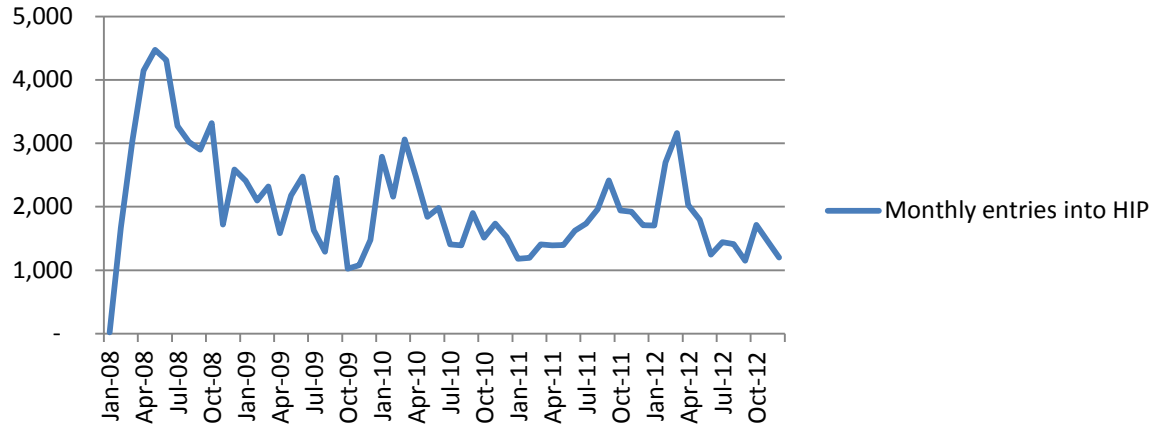
Figure 6.1: Monthly HIP Enrollment, Overall and by Caretaker Status, January 2008-December 2012.



Source: ICES data, September 2013

Monthly enrollment figures are affected by the number of people entering and leaving the program each month. Figure 6.2 shows the number of people that entered the program each month from January 2008-December 2012.

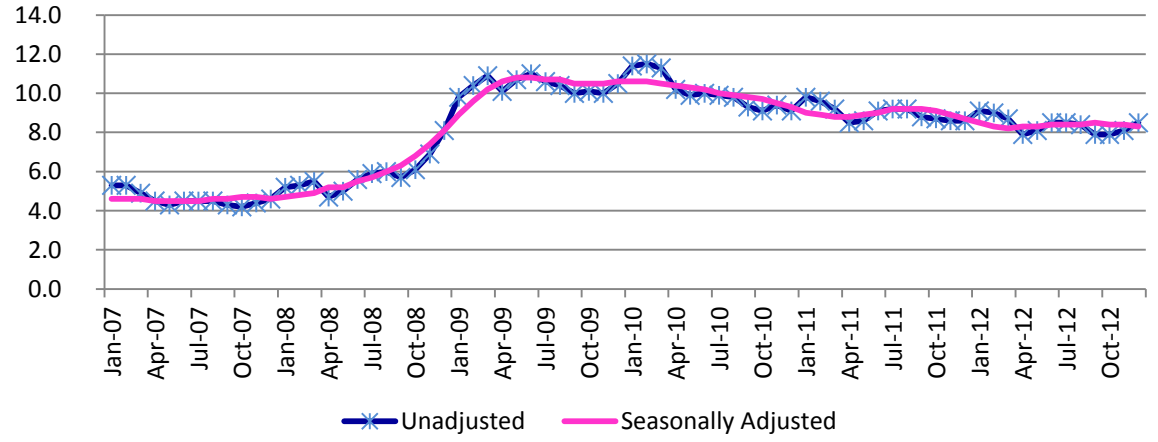
Figure 6.2 Monthly Entries into HIP, January 2008 – December 2012



Source: ICES data, September 2013

Because Hoosiers must be uninsured for at least six months before becoming eligible for HIP, trends in unemployment rates are of interest. Hoosiers that otherwise fit the eligibility criteria for HIP who previously had employer-sponsored insurance may lose it due to becoming unemployed, or allow any privately-purchased covered to lapse due to a loss of income. For months with high program entry numbers, there may be a spike in unemployment rates six months earlier Monthly enrollment spiked in April of 2010 and April of 2012 (after the non-caretaker waiting list was re-opened (early spikes were likely related to the program's inception). No significant unemployment figure six-month lag/enrollment spike correlation is observed, likely because there are too many other factors at play, including the non-caretaker cap and subsequent re-opening of the waitlist.

Figure 6.3: Monthly Unemployment Rates in Indiana: January 2007-December 2012

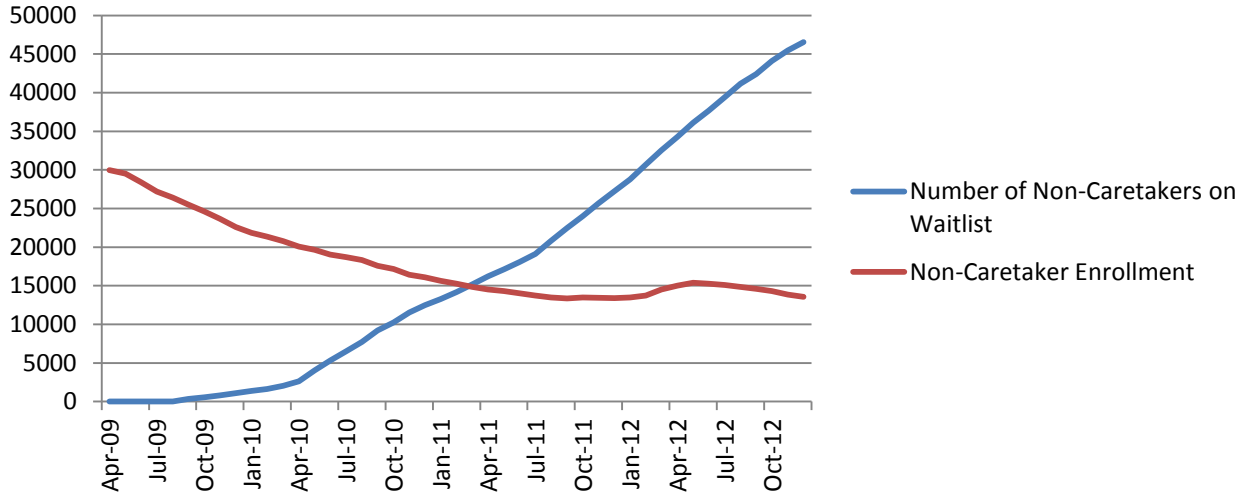


Source: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics. Available at: http://www.bls.gov/data/#unemployment

After non-caretaker enrollment was capped in March 2009, the waitlist continued to grow and non-caretaker enrollment declined through January of 2012 (see Figure 6.4). In November 2009, 5,000 letters were sent to individuals on the waiting list inviting them to re-apply for HIP. In August 2011, the waitlist was opened to 8,000 additional members. By the end of December 2011, 19,500 letters had been sent and 2,157 individuals on the waiting list had enrolled in the program (11 percent response rate). Due to the length of time many applicants had spent on the waiting list, some individuals who received letters may have experienced a life change, such as moving out of state or no longer meeting eligibility criteria for the program.

During the first quarter of the 2012 calendar year, 18,800 letters were sent to non-caretakers caretakers on the waitlist, inviting them to reapply for the program. In response to these letters, 1,587 individuals were able to enroll, an 8.4 percent response rate (see Figure 6.4). During this time, 7,113 additional individuals were added to the waitlist. The waitlist was closed to new non-caretaker applicants in April 2012 as the State waited for guidance from CMS on whether HIP could be used as a framework for a potential Medicaid expansion under the Affordable Care Act of 2010.

Figure 6.4 Non-Caretaker Waitlist and Non-Caretaker Enrollment, April 2009-December 2012



B. DEMOGRAPHIC CHARACTERISTICS OF THOSE EVER ENROLLED IN HIP

The State's analyses of HIP enrollment records indicate that HIP served 56,245 unique individuals during 2012 and 105,197 individuals over the five demonstration years. The demographics of HIP enrollees in 2012 compared to the enrollment composition over the life of the demonstration are somewhat similar (Table 6.1). The proportion of females in HIP was slightly higher in 2012, though women have made up a majority of the HIP population over the course of the program. HIP enrollees in 2012 were slightly older when compared to composite

enrollment statistics from 2008-2012. In 2012, 14 percent of enrollees were ages 20-29, as compared to 18 percent over the five-year demonstration, while percentages of those in the 30-39, 40-49, and 50-59 age groups were slightly higher in 2012. Enrollment of African-Americans was slightly lower in 2012 (10 percent) than over the life of the program (12 percent). Member income distribution is fairly similar when comparing 2012 enrollment with cumulative enrollment.

Table 6.1. Demographic Characteristics of Those Ever Enrolled in HIP in 2008-2012 vs. 2012

	2008-2012 Enrollment	2008-2012 % of Total	2012 Enrollment	2012 % of Total	Low-Income Uninsured Working-Age Indiana Adults, 2011	Low-Income Uninsured Working-Age Indiana Adults, 2011 % of Total
Gender						
Female	68,378	65%	38,030	68%	233,201	48.9%
Male	36,819	35%	18,215	32%	243,356	51.1%
Age Group						
<20	79	0%	21	<1%	11,511	2.4%
20-29	19,394	18%	7,680	14%	151,246	31.7%
30-39	30,400	29%	17,251	31%	116,116	24.4%
40-49	28,391	27%	16,407	29%	98,753	20.7%
50-59	19,446	18%	11,130	20%	74,771	15.7%
60+	7,486	7%	3,756	7%	24,160	5.1%
Race/Ethnicity						
Asian	1,581	2%	1,159	2%	7,871	1.7%
Black	12,948	12%	5,895	10%	67,459	14.2%
Hispanic	3,591	3%	1,927	3%	69,404	14.6%
American Indian	74	0%	45	<1%	6,171	1.3%
Other	1,695	2%	1,083	2%	35,922	7.5%
White	85,308	81%	46,136	82%	369,571	77.6%
Income as % of FPL						
<22%	30,265	28.7%	15,570	27.7%	65,297	13.7%
23%-50%	11,321	10.8%	6,780	12.1%	47,536	10.0%
51%-100%	31,330	29.9%	17,145	30.4%	121,812	25.6%
100%-150%	21,083	20%	11,123	19.8%	133,837	28.1%
>150%	11,197	10.6%	5,627	10%	108,075	22.7%

Source: ACS data, 2011.

6.2 GOAL II – REDUCE BARRIERS AND IMPROVE STATEWIDE ACCESS TO HEALTH CARE SERVICES FOR LOW-INCOME HOOSIERS

A key goal of HIP is to improve access to health care among low-income Hoosiers. To accomplish this goal, it is important not only to provide health insurance, but also to ensure that HIP members have access to both a primary medical provider (PMP) and needed specialists. Over the past five years, HIP has consistently achieved this goal by providing full access to PMPs and access to most specialists.

A. PROVIDER NETWORKS

1. Primary Care Providers

In 2012, all HIP members were required to select a PMP, or were auto-assigned to a provider. All three plans use Geo-Access software on a quarterly basis to evaluate whether their network meets the standard of access: a PMP within 30 miles of all members' homes. In 2012, all plans continued to meet geo-access standards for PMPs. The health plans reported that HIP's higher payment rate has not been a significant factor in their ability to recruit providers. Most HIP providers already serve both HHW and HIP patients, and have therefore already accepted Medicaid reimbursement rates. HIP reimburses most services at Medicare rates. The plans have noted that some providers have faced billing challenges during the demonstration, as not every service provided to Medicaid patients has a corresponding Medicare billing code.

In addition to seeking primary care with PMPs, HIP members may also go to any Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). All health plans reported contracting with most FQHCs, community mental health centers (CMHCs), and RHCs in the State.

2. Specialty Care

In the first year of HIP operations, development of specialist networks was a challenge for Anthem and MDwise, the initial HIP health plans. However, these plans made significant strides in expanding their networks since then, and by the end of 2012 both reported that members had access to most categories of specialists within 60 miles of their homes. During its initial year, MHS met geo-access standards for approximately half of its specialist categories, and made significant improvements during 2012.

All plans reported meeting geographic access standards in most categories during 2012, and provided transportation services to members when necessary. The plans noted a few types of specialists that are difficult to locate within certain geographic areas, including nephrologists and those providers offering prosthetics, making it difficult to meet standards in these categories. However, all three plans reported that they had made efforts during 2012 to maintain their specialist networks.

In 2012, Anthem met the requirements for specialist access standards in all areas except for endocrinology, hematology, occupational therapy, and speech pathology, the same areas which

lacked sufficient access in 2011. No access information was available for the specialty areas of clinical psychology and diagnostic radiology. Between 2011 and 2012, Anthem expanded the number of specialists in its network in all categories except for neurosurgery and radiation oncology, though even these categories have been expanded since 2008. No information was available on the number of diagnostic radiology specialists available in 2011 or 2012. No 2011 information on the number of clinical psychologists in the network was available, though Anthem expanded the number of specialists in this category from 3,321 in 2010 to 5,432 in 2012.

Table 6.2. Anthem Specialist Network, 2008-2012

Specialty Type	Providers in 2008	Providers in 2009	Providers in 2010	Providers in 2011	Providers in 2012	% Change 2008-2012	Total Number of Provider Locations 2012	Complete Coverage of Indiana, with 60-Mile Radius from Providers
Anesthesiology	88	170	199	219	219	148.9%	179	✓
Cardiovascular	1,276	2,713	3,261	2,866	3,124	144.8%	375	✓
Clinical Psychology	1,726	2,720	3,321	*	5,432	214.7%	948	*
Dermatology	32	87	127	181	213	565.6%	71	✓
Diagnostic Radiology	159	201	247	*	*		*	*
Endocrinology	48	129	159	159	168	250.0%	76	
Gastroenterology	210	332	351	376	556	164.8%	142	✓
General Surgery	335	658	739	813	951	183.9%	268	✓
Hematology	129	221	216	225	228	76.7%	105	
Infectious Disease	32	184	198	199	210	556.3%	67	✓
Medical Oncology	696	829	863	817	913	31.2%	171	✓
Nephrology	208	462	683	1,032	1,194	474.0%	207	✓
Neuro Surgery	103	135	240	261	252	144.7%	73	✓
Neurology	257	1,339	1,460	1,589	1,617	529.2%	214	✓
Occupational Therapy	49	64	84	95	121	146.9%	101	
Ophthalmology	388	565	594	740	779	100.8%	264	✓
Optometry	346	459	494	573	688	98.8%	266	✓

Specialty Type	Providers in 2008	Providers in 2009	Providers in 2010	Providers in 2011	Providers in 2012	% Change 2008-2012	Total Number of Provider Locations 2012	Complete Coverage of Indiana, with 60-Mile Radius from Providers
Orthopedic Surgery	330	462	603	685	849	157.3%	245	✓
Otolaryngology	444	567	751	910	1,012	127.9%	273	✓
Pathology	32	35	45	40	45	40.6%	39	✓
Physical Therapy	99	133	177	180	211	113.1%	183	✓
Pulmonary Disease	214	472	522	558	594	177.6%	211	✓
Radiation Oncology	439	635	605	567	629	43.3%	123	✓
Rheumatology	35	138	156	135	148	322.9%	76	✓
Speech Pathology	11	18	20	21	22	100.0%	22	
Urology	500	546	637	790	798	59.6%	182	✓
TOTAL	**8,186**	**14,274**	**16,752**	**At least 14,031**	**At least 21,121**	**At least 73.2%**	**At least 4,881**	**At least 20 of 26**

Source: Anthem Specialists 2012 Summary

Note: * indicates information not available.

In 2012, MHS met geo-access standards in all categories except for anesthesiology, dermatology, endocrinology, neurosurgery, pathology, physical therapy, and speech pathology. The plan notes that it meets the 90-mile access standards for all of these specialties except speech pathology. Between 2011 and 2013 (the date for which MHS provided information), MHS expanded or maintained its specialist networks in most categories, except for hematology, infectious disease, neurology, and physical therapy. No information was available to determine whether MHS had enough diagnostic radiologists in its network to meet standards.

Table 6.3. MHS Specialist Network, 2011-2013

Specialty Type	Number of Providers 2011	Number of Providers 2013	% Change 2011-2013	Total Number of Provider Locations 2013	Complete Coverage of Indiana, with 60-Mile Radius to Providers
Anesthesiology	211	211	0.0%	49	

Specialty Type	Number of Providers 2011	Number of Providers 2013	% Change 2011-2013	Total Number of Provider Locations 2013	Complete Coverage of Indiana, with 60-Mile Radius to Providers
Cardiovascular	275	347	26.2%	156	✓
Clinical Psychology	264	394	49.2%	244	✓
Dermatology	53	535	909.4%	27	
Diagnostic Radiology	244	244	0.0%	*	*
Endocrinology	41	41	0.0%	34	
Gastroenterology	168	176	4.8%	64	✓
General Surgery	316	352	11.4%	157	✓
Hematology	137	86	-37.2%	60	✓
Infectious Disease	37	30	-18.9%	23	✓
Medical Oncology	**	86		60	✓
Nephrology	87	100	14.9%	46	✓
Neurosurgery	41	72	75.6%	28	
Neurology	182	100	-45.1%	46	✓
Occupational Therapy	23	33	43.5%	24	✓
Ophthalmology	94	112	19.1%	53	✓
Optometry	72	113	56.9%	57	✓
Orthopedic Surgery	223	275	23.3%	131	✓
Otolaryngology	131	139	6.1%	58	✓
Pathology	91	117	28.6%	25	
Physical Therapy	85	77	-9.4%	38	
Pulmonary Disease	101	113	11.9%	68	✓
Radiation Oncology	57	58	1.8%	37	✓
Rheumatology	7	32	357.1%	27	✓
Speech Pathology	14	17	21.4%	9	
Urology	137	153	11.7%	61	✓
TOTAL	**At least 3,091**	**At least 4,013**	**At least 29.8%**	**At least 1,582**	**At least**

Specialty Type	Number of Providers 2011	Number of Providers 2013	% Change 2011-2013	Total Number of Provider Locations 2013	Complete Coverage of Indiana, with 60-Mile Radius to Providers
					18 of 26

Source: MHS Specialists Summary, 2013

Note: * indicates information not available. MHS provided information for 2013 and not for 2012.

In 2012, MDwise met geo-access standards for all specialist areas except for dermatology and nephrology. Between 2008 and 2012, it expanded its access in all specialty areas except for dermatology.

Table 6.4. MDWise Specialist Network, 2008-2012

Specialty Type	Number of Locations 2008	Number of Locations 2009	Number of Locations 2010	Number of Locations 2011	Number of Locations 2012	% Change 2008–2012	Complete Coverage of Indiana, with 60-Mile Radius from Providers
Anesthesiology	91	134	609	197	237	160%	✓
Cardiovascular	149	245	340	335	403	170%	✓
Clinical Psychology	9	9	383	333	405	4,400%	✓
Dermatology	369	387	37	45	50	-86%	
DME and Prosthetic Suppliers	33	42	81	252	247	648%	✓
Gastroenterology	37	51	117	137	164	343%	✓
General Surgery	82	113	234	270	346	321%	✓
Gynecology	99	124	280	370	515	420%	✓
Home Health	13	16	29	55	103	692%	✓
Nephrology	28	46	101	124	150	435%	
Neuro Surgery	13	13	60	44	74	469%	✓
Neurology	37	44	155	167	190	413%	✓
Oncology	24	40	99	190	237	887%	✓
Ophthalmology	23	32	92	156	194	743%	✓
Optometry	11	14	71	149	158	1,336%	✓
Orthopedic Surgery	56	69	139	193	247	341%	✓
Otolaryngology	46	44	95	124	145	215%	✓

Pathology	20	29	129	189	213	965%	✓
Physical Therapy	15	30	176	222	272	1,713%	✓
Psychiatry	7	346	314	231	265	3,685%	✓
Pulmonary Disease	39	48	90	151	196	402%	✓
Radiology	131	253	380	183	219	67%	✓
Urology	22	65	107	138	158	618%	✓
TOTAL	**1,354**	**2,194**	**4,118**	**4,255**	**5,188**	**283%**	**21 of 23**

Source: MDwise specialists summary, 2013.

B. MEMBER PERCEPTIONS OF COST SHARING REQUIREMENTS

To examine access to care among members and to evaluate whether HIP's cost sharing requirements serve as a barrier to coverage for low-income Hoosiers, Mathematica conducted a telephone survey of 847 current HIP members who had been enrolled at least two years at the time of the survey. Another survey of 613 "leavers," individuals who had been enrolled in HIP within the last 12 months but were not enrolled at the time of the survey, was also conducted. When the survey weights are applied, the respondents to the survey of current HIP members represent 16,830 current members who have been enrolled at least two years and the respondents to the survey of HIP leavers represent 4,049 former members. Survey respondents shared their perceptions of cost-sharing requirements (including POWER account contributions and ER co-payments).

1. Monthly POWER Account Contributions

General Perception of the Method of Contributing to the Cost of Healthcare: The 2013 survey assessed currently enrolled HIP members' preferences for the method of contributing to their healthcare costs (up-front contributions versus making copayments at the time of service). A significant majority of HIP members (83.1 percent) reported that when given the choice between paying a fixed monthly amount up front with the opportunity to receive funds back and making a payment each time they visited a health professional, pharmacy, or hospital, they preferred to pay up front (make a POWER account contribution). Members with incomes above 100 percent of the FPL were slightly more likely to report a preference for paying up front than those at or below 100 percent of the FPL (86.2 percent versus 81.6 percent, respectively).

Table 6.5. Preferred Method of Contributing to Healthcare Costs

	All Respondents	≤ 100% FPL	> 100% FPL
Number of Members	16,830	11,477	5,353
Prefer paying up front (POWER account)	83.1%	81.6%	86.2%
Prefer paying each doctor visit	13%	15%	8.9%

	All Respondents	≤ 100% FPL	> 100% FPL
(copayments)			
Refused/Don't Know	3.9%	3.4%	4.9%

General Perception of the Size of the Monthly Contribution. In the survey samples, 84 percent of current HIP members and 82 percent of former HIP members contributed to their POWER accounts. Among those who made a monthly contribution to their HIP POWER accounts, approximately three quarters of current HIP members felt that their monthly contributions were "the right amount," and nearly 85 percent believed the amount was either right or below the right amount. Former HIP members had the same perception of the contributions they made while enrolled; 74 percent believed they were the right amount and 82 percent believed they were either the right amount or below the right amount. Compared to HIP members, former members were slightly more likely to report that their contributions had been too much, 17 percent compared to 14 percent. Members' perception of their contributions varied by income, but the variation was not consistent between current and former members. Current HIP members with incomes at or below 100 percent of FPL were the group most likely to report the monthly contribution was the right amount or too low (87 percent), whereas former HIP members with income at or below 100 percent of FPL were the least likely to report the amount was right or too low (79 percent). Those with income above 100 percent of FPL fell in between, with former HIP members in this income range more likely to report the monthly contribution was right or too low (84 percent) compared to current HIP members in the same income group (82 percent).

Table 6.6. Perception of Monthly Contributions (Weighted Data)

Perception of Monthly Contribution	All Respondents Who Made Monthly Contributions		≤100% FPL		> 100% FPL	
	Current Members	Former Members	Current Members	Former Members	Current Members	Former Members
Number of Members	14,126	3,295	9,059	1,468	5,067	1,361
Too much	14.3%	16.8%	11.9%	19.9%	18.6%	15.4%
The right amount	76.3%	73.5%	78.6%	71.9%	72.1%	74.4%
Below the right amount	8.6%	8.8%	8.2%	7.4%[b]	9.4%[b]	9.4%[b]
Don't know	0.4%[b]	0.7%[b]	0.7%[b]	0.5%[b]	0.0%[b]	0.9%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.

Notes: Approximately 14.2 percent of respondents to the survey of former HIP members did not provide income information. These respondents are included in the "all respondents" column, but not in those containing income breakdowns. The source information for income varied by survey sample. For current HIP members, income information came from HIP administrative records and was therefore the income at the time of the member's last annual redetermination. Respondents to the survey of former HIP members were asked to report their income at the time of the survey, which was necessarily after they had disenrolled in HIP.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Worries About Ability to Pay the Monthly Contribution. Current and former HIP members reported similar rates of worrying about having enough money to pay their monthly contributions (Table 6.7). Approximately 81 percent reported that they sometimes, rarely or never were worried about having enough money to pay their monthly contribution. Conversely, 17 percent of current HIP members and 19 percent of former members reported that they "always" or "usually" worried about having enough money to pay their monthly contributions. Income appears to have an important association with this type of worry among former HIP members. The percentage of former HIP members who reported they sometimes, rarely, or never worried about their monthly contributions ranged from 75 percent among those with income at or below 100 percent of FPL to 85 percent among those with income above 100 percent of FPL. Current HIP members did not show the same level of variation in responses and income did not appear to have an important association.

Table 6.7. Worries About Paying Monthly Contributions Among Members Who Made Monthly Contributions (Weighted Data)

Frequency of Worrying About Paying Their Monthly Contribution	All Respondents Who Made Monthly Contributions		≤100% FPL		> 100% FPL	
	Current Members	Former Members	Current Members	Former Members	Current Members	Former Members
Number of Members	14,126	3,295	9,059	1,468	5,067	1,361
Always/Usually	17.3%	19.0%	16.8%	24.8%	18.2%	14.7%[b]
Sometimes	32.9%	32.0%	31.1%	34.1%	36.1%	29.6%
Rarely	18.9%	22.0%	19.0%	18.3%	18.9%	25.8%
Never	29.5%	27.0%	32.3%	22.8%	26.3%	29.9%
Don't know	0.7%[b]	0.0%[b]	0.9%[b]	0.0%[b]	0.4%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.

Notes: Approximately 14.2 percent of respondents to the survey of former HIP members did not provide income information. These respondents are included in the "all respondents" column, but not in those containing income breakdowns. The source information for income varied by survey sample. For current HIP members, income information came from HIP administrative records and was therefore the income at the time of the member's last annual redetermination. Respondents to the survey of former HIP members were asked to report their income at the time of the survey, which was necessarily after they had disenrolled in HIP. The questions posed to current HIP members and former members varied slightly. Members were asked how often they were worried about having enough money to pay their monthly contributions over the last 12 months. Former members were asked how often they were worried about having enough money to pay their monthly contribution while they were enrolled in HIP.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Former members were also asked to report how often they had worried about their medical expenses at the time of the survey. Overall, 54 percent of former members reported "always" or "usually" worrying about their medical expenses, which was much higher than the 19 percent who reported that they had "always" or "usually" worried about their monthly payments (Table 6.8). While former members with incomes above 100 percent of FPL were more likely than those at or below the FPL to report "rarely" or "never" worrying about either monthly payments

or medical expenses, both groups reported worrying about current medical expenses more frequently than they had worried about their monthly payments.

Table 6.8. Former Members' Frequency of Worrying about Monthly Contribution and Medical Expenses (Weighted Data)

Frequency of Worrying About Payment/Expenses	All Respondents Who Made Monthly Contributions		≤ 100% FPL		> 100% FPL	
Number of Former Members	3,295		1,468		1,361	
	Monthly Payment	Medical Expenses	Monthly Payment	Medical Expenses	Monthly Payment	Medical Expenses
Always/usually	19%	51.1%	24.8%	54.6%	14.7%[b]	49.2%
Sometimes	32.0%	23.7%	34.1%	23.1%	29.6%	24.7%
Rarely/never	49.0%	22.6%	41.1%	19.1%	55.7%	24.7%
Don't Know	0.0%[b]	0.4%[b]	0.0%[b]	0.5%[b]	0.0%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns. 2.9 percent of respondents who made monthly contributions did not provide information on their frequency of worrying about medical expenses.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

At the time of the survey, over half of former members said that they were currently uninsured, while 22 percent had gained public insurance through Medicare or Medicaid and 20 percent had gained private insurance through an employer or by purchasing an individual policy (Table 6.8). Individuals reporting income at or below 100 percent FPL at the time of the survey were more likely to have public insurance than private (27 percent versus 12 percent). Of those reporting income greater than 100 percent FPL, 13 percent reported having public insurance coverage, while 31 percent had private coverage. Former HIP members who were uninsured at the time of the survey were more than twice as likely as those with public or private insurance to say that they "always" worried about medical expenses. Uninsured former members below the FPL were more likely than those above the FPL to say they were "always" or "usually" worried about their medical expenses (74 percent versus 67 percent). Though the uninsured worried about medical expenses at far higher rates than those with insurance, individuals with public insurance were more likely than those with private insurance to say that they "rarely" or "never" worried about their medical expenses. Though higher-income individuals appear to worry less often about medical expenses than those with income at or below 100 percent FPL, the number of individuals in each income group is too small to provide reliable data.

Table 6.9: Former Members' Frequency of Worrying about Medical Expenses by Insurance Status (Weighted Data)

Frequency of Worrying About Medical Expenses	All Respondents			≤ 100% FPL			> 100% FPL		
	Uninsured	Public	Private	Uninsured	Public	Private	Uninsured	Public	Private

Number of Members	2,230	870	809	1,054	491	220	836	211	496
Always/Usually	69.4%	32.5%	35.7%	74.0%	35.6%	34.8%[b]	67.1%	27.8%[b]	33.5%[b]
Sometimes	15.5%	30.3%	34.0%	12.7%[b]	29.6%[b]	45.8%[b]	18.0%[b]	34.2%[b]	30.8%[b]
Rarely/never	10.5%	37.2%	30.3%	8.8%[b]	34.9%	19.5%[b]	12.8%[b]	38.0%[b]	35.7%[b]
Don't know	0.7%[b]	0.0%[b]	0.0%[b]	0.8%[b]	0.0%[b]	0.0%[b]	0.0%[b]	0.0%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Willingness to Pay a Higher Monthly Contribution. Current HIP members were overwhelmingly willing to pay more each month to remain enrolled in HIP (Table 6.10). Among those currently making monthly contributions, nearly 94 percent are willing to pay $5 more each month and 88 percent are willing to pay $10 more to remain enrolled in HIP. Among those members who were not making monthly contributions, 82 percent reported that they would be willing to pay $5 each month for HIP coverage, while 75 percent said they would be willing to pay $10 each month. Willingness to pay more was fairly consistent between income groups.

Table 6.10. Member Willingness to Contribute More (Weighted Data)

Willingness to Contribute More	All Respondents		≤100% FPL		> 100% FPL	
	Current Contributors	Current Non-Contributors	Current Contributors	Current Non-Contributors	Current Contributors	Current Non-Contributors
Number of Members	14,126	2,643	9,059	2,378	5,067	266
Would pay $5 more	93.5%	81.7%	93.0%	81.4%	94.5%	85.0%[b]
Would pay $10 more	88.1%	75.0%	87.7%	74.8%	88.6%	77.2%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.
Notes: Former members were not asked whether they would have paid more to remain in the program.

[b] These estimates may be unreliable because they are based on less than 30 respondents.

Program Costs and Disenrollment. Among those surveyed members who disenrolled from HIP within the past year, program costs were only cited by 14 percent as the reasons for disenrolling (Table 6.11). More commonly, former members indicated they did not follow the requirements necessary to redetermine their eligibility (28 percent) or obtained other insurance (14 percent obtained other public insurance such as regular Medicaid or Medicare and 12 percent obtained private coverage). Twelve percent disenrolled specifically because they forgot to pay their monthly contribution (data not shown and subsumed in the group that did not follow the requirements necessary to redetermine eligibility).

Some variation by income was observed, with 19 percent of former members at or under 100 percent FPL reporting that they left due to cost, compared with 9 percent among those above 100 percent of FPL (Table 6.11). In addition, former members at or under 100 percent FPL were disproportionately more likely to have left because they gained other public insurance (Medicare or Medicaid), while those above 100 percent FPL were disproportionately more likely to have gained private insurance.

Table 6.11. Former Members' Reasons for Disenrolling from HIP (Weighted Data)

Reason for Leaving HIP	All Respondents	≤ 100% FPL	> 100% FPL
Number of Members	4,049	1,836	1,594
Cost too much	14.2%	19.0%	8.8%[b]
Didn't complete paperwork in time/Forgot to re-enroll/Forgot monthly payment	28.3%	30.7%	27.3%
Process issue	8.6%	9.3%[b]	6.6%[b]
Gained other public insurance	13.5%	16.5%	8.7%[b]
Gained private insurance	12.3%	7.8%[b]	18.8%
Reported other unspecified insurance	7.3%	8.1%[b]	7.3%[b]
Increase in income	10.1%	5.7%[b]	16.1%
Other	10.9%	9.9%[b]	9.9%[b]

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: Respondents had the option to select more than one reason for disenrolling in HIP. 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns. Former members were asked to report their income at the time of the survey, which was necessarily after they had disenrolled in HIP.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

2. Costs as a Barrier to Care.

Members were also asked about the frequency with which they had needed medical care in the last six months, but had decided not to seek it. Only 12 percent of members reported at least one instance where they decided not to seek care despite needing it (data not shown). Respondents had varied reasons for not seeking care, but cost was not a major factor, with only 6 individuals reporting cost as the reason.

3. Emergency Room Copayments

Current HIP ER co-payments range from $3 to $25, depending on caretaker status and income. Overall, 72 percent of members never utilized the ER during the past six months (Table 6.12). Of the 28 percent of members who went to the ER at least once in this time frame, 60 percent

reported that they were never asked to pay a copayment, while 28 percent said that they were asked to pay each time. Of the members who were asked to pay a copayment, 79 percent reporting being able to pay it. While this ability appeared to vary by income (with more individuals at or below 100 percent FPL reporting an inability to pay the copay), the number of individuals asked to pay a copay was extremely small, and when this group was further broken down by income, the number of individuals in each category became too small to produce reliable estimates. Survey respondents were also asked whether the ER copayment policy ever caused them to decide not to go to the emergency room. Less than seven percent of members reported that they avoided the ER because of the copayment (data not shown).

Table 6.12. Emergency Room Copayments and Current Members' Use of the Emergency Room (Weighted Data)

ER Copayment and usage	Respondents
Total number	16,830
Percent of members who went to ER in past 6 months	27.8%
Of Members Who Decided Not to Go to ER Because of the Copayment	
Number	1,093
Got care someplace else	39.7%[b]
Did not get care	60.3%
Of members who went to ER in past 6 months:	
Number	4,670
Asked to pay a co-pay every time	27.9%
Sometimes asked to a pay a co-pay	5.0%[b]
Never asked to pay a co-pay	59.5%
Admitted to hospital each time	5.0%[b]
Don't know	2.6%[b]
Of members asked to a make a co-pay:	
Number	1,537
Able to pay it	78.8%
Not able to pay it	21.2%[b]
Don't know	0.0%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

When asked their thoughts on paying a $25 co-payment to go to the emergency room, the majority of non-caretaker, current members (68 percent) reported that it would be the right amount or below the right amount, while approximately a third (31 percent) said that it would be too much (Table 6.13). This perception varied by income, with 36 percent of members at or under 100 percent FPL saying this would be too much, compared to 22 percent of members above 100 percent FPL.

Table 6.13. Perception of $25 Copayment, By Income (Weighted Data)

Perception of a $25 ER Copayment	All Respondents	≤ 100% FPL	> 100% FPL

Number of Members	16,830	11,477	5,353
Too much	31.4%	35.7%	22.3%
The right amount	62.6%	58.3%	71.8%
Below the right amount	5.0%	4.9%	5.2%[b]
Don't know	0.9%[b]	1.0%[b]	0.7%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

6.3 GOAL III – PROMOTE VALUE-BASED DECISION-MAKING AND PERSONAL HEALTH RESPONSIBILITY

HIP employs a number of financial incentives in an effort to encourage members to become thoughtful health care purchasers and active participants in maintaining or improving their health. These incentives begin upon enrollment, when most HIP members are required to contribute to the cost of their care by making monthly contributions to their POWER accounts.

To assess the goal of value-based decision-making, the 2013 survey asked current and former HIP members about their knowledge of HIP program policies and incentives. The survey sought to assess whether members were knowledgeable about (1) the POWER account feature; (2) the status of their own POWER account; (3) incentives built into the program to encourage preventive care, such as rollovers; and (4) incentives built into the program to discourage non-emergent use of the ER. Key findings include:

- Most HIP members had heard of the POWER account, and many check the balance in their account at least monthly.
- More education is likely necessary to ensure that HIP members fully understand the link from securing preventive care to receiving a rollover to benefiting from reduced monthly contributions.
- Most respondents were aware of the required ER copayment. However, of the respondents who utilized the ER, the majority were not asked to make a copayment.

A. POWER ACCOUNT CONTRIBUTIONS

In 2012, about 77 percent of those eligible for HIP were required to make contributions to their POWER account.[14] This rate has increased since 2008, when 65 percent of members were required to make a contribution.

[14] The percentage of HIP members required to make a monthly contribution is somewhat higher than the percentage that actually make the contribution. MHS reports that while the majority of its members are required to pay a monthly contribution, they waive the payment if the monthly contribution is less than a dollar each month due to the administrative costs associated with collecting and monitoring these payments.

Employers may pay for a portion of the employees' monthly contributions. Health plans provide information for members to give their employers about their ability to provide HIP subsidies for employers; however, few have taken up this option. As of December 2012, 34 employers had contributed $10,834.90 on behalf of 38 Anthem members, for an average employee contribution of $285.13. MDwise had seven employers contribute $4,822.20 to POWER accounts for nine HIP members for an average employer contribution of $535.80. MHS received $2,523.55 from five employers for six members, for an average employee contribution of $420.59.

Mathematica's 2013 survey of current members asked respondents about their experiences requesting employer assistance with the monthly contributions. Forty-one percent of currently employed members reported that they were aware that employers could help to pay their monthly contributions (Table 6.14). Among those aware of the employer option, 83 percent of members with incomes at or below the FPL and 67 percent with incomes above the FPL reported that they had not asked their employers for assistance. Across income groups, the most popular reason for not asking was that members were confident that their employers would say no. Of the members who asked their employers for assistance, 92 percent reported that their employers had said no. However, the number of individuals who chose to ask their employers is too small to provide reliable information.

Table 6.14. Member Experiences Requesting Employer Assistance With Monthly Contributions (Weighted Data)

Member Experiences with Employer Assistance	Currently Employed Respondents	≤100% FPL	>100% FPL
Number of members	5,500	3,222	2,279
Aware that employers could help pay monthly contribution			
Yes	41.0%	40.3%	42.0%
No	53.6%	53.6%	53.7%
Don't Know	1.5%	1.8%	0.9%
Of those aware:			
Number	2,254	1,297	957
Have asked employer to help pay monthly contribution			
Yes	23.1%[b]	17.4%[b]	30.9%[b]
No	76.0%	82.6%	66.9%
Don't Know	0.0%[b]	0.0%[b]	0.0%[b]
Of those who asked:			
Number	521	226	296
Employer response:			
Agreed to pay all of contribution	8.0%[b]	9.3%[b]	7.1%[b]
Agreed to pay part of contribution	0.0%[b]	0.0%[b]	0.0%[b]
Did not agree to contribute	92.0%[b]	90.8%[b]	92.9%[b]
Still deciding	0.0%[b]	0.0%[b]	0.0%[b]
Other	0.0%[b]	0.0%[b]	0.0%[b]
Don't Know	0.0%[b]	0.0%[b]	0.0%[b]

Member Experiences with Employer Assistance	Currently Employed Respondents	≤100% FPL	>100% FPL
Of those who did not ask:			
Number	1,712	1,071	641
Reason for not asking[a]:			
Didn't know who to ask	2.4%[b]	3.9%[b]	0.0%[b]
Afraid of losing my job/Asking may jeopardize my job	9.2%[b]	9.2%[b]	9.2%[b]
Confident my employer would say no	40.0%	33.4%[b]	50.9%[b]
Didn't want employer to know I'm on HIP	3.4%[b]	3.7%[b]	3.0%[b]
Felt like I was asking for a favor	4.7%[b]	5.7%[b]	3.0%[b]
Other	2.3%[b]	1.8%[b]	3.3%[b]
Don't know	7.2%[b]	7.2%[b]	0.0%[b]

Source: Mathematica 2013 survey of current HIP members.

[a] Members were allowed to select more than one reason for not asking their employer.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

B. HIP DISENROLLMENTS

HIP uses the POWER account to promote value-based decision making and personal health responsibility among its members. Of the 126,607 Hoosiers found eligible for HIP over the five-year demonstration, 105,197 individuals (83 percent) made their first POWER account payment and fully enrolled in the program (Table 6.15), while 21,472 individuals (17 percent of those otherwise found eligible) did not. Those with incomes at or below 100 percent of the FPL were most likely not to make an initial contribution—69 percent of the initial non-contributors were at or below the poverty level.

Over the five year- period, 12,490 HIP members (12 percent of those ever fully enrolled) left the program for failure to make a subsequent POWER account contribution. The majority of those who disenrolled due to a failure to make a subsequent contribution were also at or below 100 percent of poverty (57.5 percent).

Table 6.15. Summary of Denials and Disenrollments Associated with Monthly Contributions

Types of Denials or Disenrollments	2008-2012
Number determined eligible for HIP	126,669
Number ever enrolled in HIP	105,197
Percent of those found eligible who enrolled	83%
Number who left HIP for failure to make a subsequent POWER account contribution	12,490
Percentage of those ever enrolled who left HIP for failure to make a subsequent POWER account contribution	10%
Percentage of those who disenrolled who left HIP for failure to make a subsequent POWER account contribution	10%

Source: OMPP analysis of HIP eligibility records extracted from MedInsight; OMPP data request number 7527, June 3, 2010; OMPP data request number 7939, April 3, 2011; OMPP data request 8790, October 18, 2012, OMPP data request number 9515, April 25, 2013.

In 2012, most HIP disenrollments (31.8 percent) occurred after a member did not return his or her HIP re-determination packet. The failure to make a POWER account payment accounted for the second largest number of HIP individual accounts closed during 2012, with 3,924 members (28.3 percent of total disenrollment) failing to make a subsequent POWER account payment.

Table 6.16. Top Five Types of HIP Member Counts Closed in CY 2012

Member Count	Closed Reason
13,887	Total
4,415	HIP redetermination packet not returned
3,924	Failure to make POWER Account payment
2,658	Closed due to Appeals ruling
1,805	Other current health insurance
1,085	Did not verify income

Source: OMPP data request number 9515 April 23, 2013

C. POWER ACCOUNT ROLLOVERS

The majority of HIP members who were involved in the POWER account rollover process during calendar year 2012 did not have an account balance left after 12 months (they exhausted their POWER accounts over the course of the year), which is a reflection of high level of chronic disease burden in the HIP population. Of those who did have a balance, the majority received a partial rollover (their own contributions were rolled over, but not the State's). A full rollover (member contributions plus those of the state) is received if the members meet the preventive care receipt requirement. The members who do not spend down their POWER accounts (have a balance left at the end of 12 months) may be healthier than those who do, so the observed lower rate of preventive care receipt might be due to a perception of lack of need. The MCEs continue to work to promote the preventive care incentive and develop member awareness and understanding of how the POWER account works. By the end of 2012, just over one-third of POWER accounts eligible for a rollover over the course of the demonstration contained any funds to carry forward after 18 months of enrollment. Of the accounts with a remaining balance, about 65 percent received partial rollovers and about 35 percent received full rollovers.

D. MEMBER KNOWLEDGE OF POWER ACCOUNTS

The POWER account is structured to incentivize the use of preventive services among HIP members because they can reduce their future monthly contributions if they obtain appropriate preventive services, available at no cost. Members who do not use their entire POWER accounts during the course of a year will have the remainder of the account "rolled over" to the next year.

State subsidies are also rolled over, as long as members have met their preventive services requirements. The amount rolled over is then used to reduce the member's future monthly contributions.

For the incentive structure to work as intended, members must understand the POWER account and the program's mechanisms for reducing their monthly contribution. Maximus, the state's enrollment broker, strives to explain the HIP program and POWER account to enrollees. However, the health plans noted that new members continue to have many questions after enrolling in HIP.

Mathematica's 2013 survey evaluated the extent to which current and former HIP members understood the POWER accounts and the HIP program incentives. Key findings include:

- More than three-quarters of current members had heard of the POWER account.
- Among current members, nearly 60 percent reported checking their POWER account at least monthly.
- More education is needed for members to fully understand program incentives. Most members believed that the cost of preventive screenings would be deducted from their POWER accounts, and many appeared unaware of the connection between the receipt of preventive services and POWER account rollovers.

Familiarity with the POWER Account. Familiarity with the POWER account was high among survey respondents. Three-quarters (77 percent) of current HIP members reported that they had heard about the POWER account (Table 6.17). This rate was slightly lower among former members (67 percent). When asked how they had learned about the POWER account, current and former members offered similar answers. The most common methods for learning about the account included the member handbook and "the health plan," though smaller percentages said they had learned about it through the HIP Web site or because "someone from the plan had called them to explain."

Table 6.17. Knowledge of POWER Account (Weighted Data)

POWER Account knowledge	Current HIP Members	Former HIP Members
Number of Members	16,830	4,048
Had ever heard or learned about the POWER Account		
Yes	76.5%	67.0%
No	22.1%	27.2%
Don't Know	1.4%	5.8%
Of those who had heard of the POWER account:		
Number	12,875	2,714
Methods of learning about the POWER account[a]		
Member handbook	44.2%	44.0%
Someone from the plan called to explain	14.4%	16.5%
HIP Web site	12.4%	9.6%
Health plan	40.5%	40.2%

POWER Account knowledge	Current HIP Members	Former HIP Members
Medical provider	4.7%	4.8%[b]
Family/Friends	6.6%	3.6%[b]
None of these	7.0%	6.4%[b]
Don't know	1.3%[b]	1.6%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.

[a]Respondents were allowed to select more than one method they used to learn about the POWER Account.

[b]These estimates may be unreliable because they are based on fewer than 30 respondents.

Knowledge of POWER Account Balance. Three quarters of current HIP members had heard of the POWER account, while nearly 60 percent of these respondents checked their account balance at least monthly (Table 6.18). Forty-seven percent reported an account balance at or below $1,100, while the remainder said they either did not know their balance, or reported an amount above $1,100 (the maximum amount for a POWER account).

Table 6.18. Knowledge of POWER Account Balance Among Current Members (Weighted Data)

Knowledge of POWER Account Balance	All Respondents Who Had Heard of POWER Account	≤100% FPL	> 100% FPL
Number of Members	12,875	8,837	4,038
Frequency with which member checks POWER account balance			
Weekly	0.6%[b]	0.9%[b]	0.0%[b]
A few times a month	2.8%[b]	2.9%[b]	2.4%[b]
Monthly	54.9%	53.5%	57.9%
A few times a year, not every month	13.3%	12.3%	15.4%
Once a year	5.3%	5.3%[b]	5.4%[b]
Never	21.1%	23.0%	16.9%
Don't know	1.9%[b]	1.8%[b]	2.0%[b]
Reported a plausible POWER account balance	47.1%	46.3%	49.0%

Source: Mathematica analysis of 2013 survey of current HIP members.

[b]These estimates may be unreliable because they are based on fewer than 30 respondents.

Knowledge of POWER Account Rollovers. Forty eight percent of current members who had heard about the POWER accounts reported that they had funds left over in their POWER Account at their last HIP renewal date, which would have made them eligible for a rollover (data not shown). About 22 percent had exhausted their POWER account and did not have any funds to roll over and thirty percent of members did not know if they had funds left in their account at the last renewal date. Because so many of those who did not know may have only recently renewed their coverage at the time of survey, this section assesses respondent's history of POWER account rollovers over their entire membership in the program.

When members who had heard about the POWER accounts were asked specifically if they had ever received a rollover during their HIP membership, 39 percent reported that they had, one-third said they had not, and 28 percent did not know (Table 6.19). Current members were more likely to report receiving a rollover compared to former members (39 percent compared to 24 percent) and members in the higher income group were more likely to receive a rollover than those in the lower income group (among current members it was a 3 percentage point difference between the two income groups compared to a 5 percentage point difference among former members).

Table 6.19. Knowledge of Effect of Rollover on Monthly Contributions, Among Current and Former Members (Weighted Data)

	Current Members Who Had Heard of the POWER Account			Former Members Who Had Heard of the POWER Account		
Knowledge/Effects of Rollover Policies	All	≤100% FPL	> 100% FPL	All	≤100% FPL	> 100% FPL
Number of Members	12,875	8,837	4,038	2,731	1,151	1,160
Ever received a rollover						
Yes	39.2%	38.1%	41.4%	24.1%	22.8%	28.3%
No	32.1%	32.7%	31.4%	60.1%	59.6%	58.9%
Don't know	28.4%	29.2%	26.7%	15.0%	17.7%[b]	12.0%[b]
Of those reporting a rollover:						
Number	5,043	3,370	1,673	537	207	282
Rollover affected size of monthly contributions						
Yes	37.3%	30.6%	50.7%	34.8%	34.9%[b]	38.5%[b]
No	50.3%	55.6%	39.7%	58.9%	61.8%[b]	57.6%[b]
Don't Know	12.4%	13.8%[b]	9.6%[b]	6.3%[b]	3.3%[b]	3.9%[b]
Of those who knew that rollover affected size of monthly contributions:						
Number	1,879	1,032	848	187	72	109
Monthly contributions went down	41.5%	40.1%[b]	43.2%[b]	64.3%[b]	93.0%[b]	48.8%[b]
No longer had to pay	45.0%	41.2%[b]	50.0%[b]	29.7%[b]	7.0%[b]	41.0%[b]
Monthly contributions went up/ Did not know	13.5%[b]	18.7%[b]	7.2%[b]	5.9%[b]	0.0%[b]	10.2%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Understanding of Relationship Between Rollovers and Monthly Contributions. Whether a current member remembered that his or her POWER account rollover affected the size of subsequent monthly contribution was closely related to their income. Overall, half of current members who reported receiving a rollover reported the rollover did not affect their monthly contribution, while 12 percent were not sure whether the rollover had affected their contribution (Table 6.19). However, members with income above 100 percent FPL were significantly more

likely than those at or below poverty to report that their rollover had affected their monthly contribution (51 percent versus 31 percent, with a p value of .0018).

Of those current members who knew that their rollover had affected their monthly contribution, most (87 percent) reported that their contribution had been reduced or had been eliminated completely. The rest either did not know how their monthly contribution was affected or reported that their monthly contribution increased as a result of the rollover.

Knowledge of Preventive Services Incentive. The survey data suggest that most current members may not be aware of the HIP policy that would allow them to get no-cost preventive care, but the results are difficult to interpret. This policy, designed to provide a financial incentive for members to obtain preventive services, allows members to obtain preventive services without having the cost deducted from their POWER accounts. When members were asked if they thought "the cost of preventive services like annual exams" would be deducted from their POWER account, 71 percent of members believed they would be deducted (Table 6.20). A similar proportion also thought that "the cost of preventive services like cancer screenings" would be deducted from the account.

Table 6.20. Current Member Knowledge of Preventive Services Policies (Weighted Data)

Knowledge of Preventive Services Policies	All Respondents Who Had Heard of POWER Account	≤100% FPL	> 100% FPL
Number of members	12,875	8,837	4,038
Believe cost of preventive services like annual exams would be deducted from POWER account	71.3%	71.1%	71.6%
Believe cost of preventive services like cancer screening would be deducted from POWER account	72.6%	73.1%	71.3%

Source: Mathematica analysis of 2013 survey of current HIP members.

However, HIP allows the health plans to place a $500 cap on the amount of no-cost preventive services members can obtain. To date, only Anthem has imposed this cap, so members of this plan may be aware of this limit. A breakdown of results by health plans reveals that Anthem members were slightly more likely than MDwise members to believe that the cost of preventive services would be deducted from their accounts (Table 6.21). The number of MHS members in the sample was too small to draw conclusions, though they appeared to be the least likely to believe the cost of preventive exams would be deducted from their POWER accounts.

Table 6.21. Current Member Knowledge of Preventive Services Policies, By Plan (Weighted Data)

Knowledge of Preventive Services Policies, Among Those Who Had Heard of POWER Account	Anthem			MDwise			MHS		
	All	≤100% FPL	>100% FPL	All	≤100% FPL	>100% FPL	All	≤100% FPL	>100% FPL
Total Number	8,998	5,993	3,005	2,803	2,060	743	273	233	40
Believe cost of preventive services like annual exams would be deducted from POWER account	72.4%	72.9%	71.2%	68.7%	67.3%	72.7%[b]	56.9%[b]	49.6%[b]	100.0%[b]
Believe cost of preventive services like cancer screening would be deducted from POWER account	75.0%	77.5%	70.0%	68.0%	66.3%	72.7%[b]	63.9%[b]	57.7%[b]	100.0%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Knowledge of Connection Between Preventive Care and Reduction of Monthly Contributions. The knowledge of current HIP members and their understanding of the link between preventive care receipt and POWER account rollovers and the reduction of their monthly contribution is mixed (Table 6.22). When those who had heard about the POWER account were asked how the receipt of preventive care services affected the POWER account rollover, if there was money to rollover to the next year, approximately one-quarter reported that getting preventive services would qualify them for a rollover. More than half indicated that they were not sure how preventive services affected the rollover, while 14 percent thought that preventive services did not affect the rollover.

Table 6.22. Knowledge and Effects of Connection Between Preventive Care and Rollover Receipt Among Current Members Who Had Heard of POWER Account (Weighted Data)

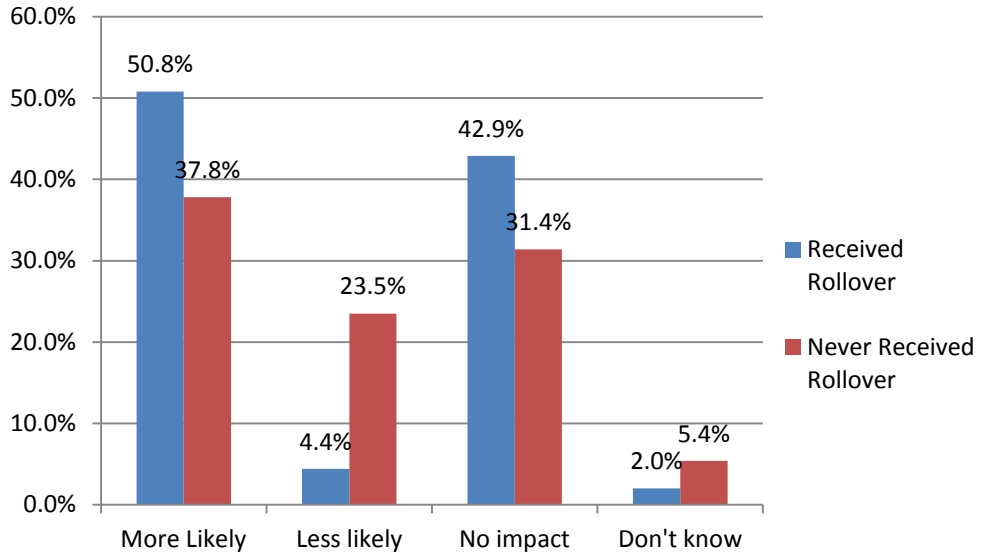
Knowledge/Effects of Rollover Policies	Current Members Who Have Heard of the POWER Account	≤100% FPL	> 100% FPL
Number of members	12,875	8,837	4,038
Understanding of relationship between preventive services and rollover			
Know that preventive services affect POWER account rollover	26.3%	24.4%	30.3%
Not sure how preventive services affect POWER account rollover	53.6%	53.8%	53.5%
Believe preventive services do not affect POWER account rollover	13.7%	14.1%	13.7%[b]
Don't know	6.1%	7.5%	3.0%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Among the 39 percent of current members who had experienced a POWER account rollover, about half reported that the rollover had made them more likely to get preventive care and 43 percent reported that it had no effect on their decision to obtain preventive care. Notably, very few members reported that receiving a rollover would make them less likely to get preventive care in the future. Members who reported never having received a rollover were split on whether the experience of not receiving a rollover would incentivize them to get preventive care in the future. Approximately 38 percent reported that not receiving a rollover had made them more likely to get preventive care in the future (Figure 6.5). About one quarter of these individuals reported that the experience of not receiving a rollover would make them less likely to get care in the future, while nearly a third reported it would have no effect. Within this group of member who had never received a rollover, some differences by income were apparent, but the sample sizes are too small for reliable estimates.

Figure 6.5: Likelihood of Seeking Preventive Care by Receipt of a POWER Account Rollover (Weighted Data)



Source: Mathematica analysis of 2013 survey of current HIP members.

Note: The sample of respondents reporting receipt of a rollover represents 5,043 current HIP members and the sample who did not receive a rollover represents 4,157 current HIP members. The estimates for the group that received a rollover and reported that the rollover made them less likely to seek preventive care and those responding they did not know how the rollover affected their likelihood of seeking preventive care may be unreliable because the information is based on less than 30 respondents.

E. EMERGENCY ROOM USAGE

The HIP program requires copayments for non-emergency use of the emergency room. This policy is intended to encourage appropriate utilization of primary care and discourage

inappropriate and costly ER use. In 2012, these co-payments varied from $3 to $25 depending on an individual's caretaker status and his or her federal poverty level (FPL). ER co-payments cannot be deducted from the member's POWER account and must be paid out-of-pocket. Additionally, individuals are provided with Explanations of Benefits for all healthcare services, including ER visits, which increase member awareness of the cost of services.

1. Emergency Room Usage in 2012: Administrative Data

According to 2012 claims data, the top reasons for ER visits were fairly similar across the three MCE's, with abdominal pain, chest, pain, and backache/lumbago emerging as some of the most common (Table 6.23).

Table 6.23. Top 5 Reasons for ER Visits, by Managed Care Entity

Anthem	MDwise	MHS
Abdominal pain	Chest pain, unspecified	Chest pain, unspecified
Chest pain	Abdominal pain, other specified site	Abdominal pain, unspecified site
Backache/lumbago/sciatica	Abdominal pain, unspecified site	Headache
Upper respiratory infection/Bronchitis	Headache	Abdominal pain, other specified site
Pain in limbs or joints	Lumbago	Lumbago

Source: Anthem, MDwise, and MHS.

During 2012, 17,584 unique HIP beneficiaries made one or more trips to the emergency room (32 percent of total enrollees). This figure includes ESP (Enhanced Service Plan) HIP members. ESP is comprised of individuals with the highest risk in the HIP population and was designed to lower health plan risk and reduce capitation rates. Members have high-risk conditions (such as cancer, HIV/AIDs, and hemophilia), or have had an organ transplant or are on the waiting list, and tend to incur high healthcare costs. In contrast, 38 percent of adult Hoosier Healthwise (HHW) members (pregnant women and low-income parents) visited the ER at least once in 2012. HHW members are not required to make co-payments for inappropriate ER use, which may partially explain the overall lower rate of ER use among HIP members.

Table 6.24 illustrates the total number of HIP and HHW member visits to the ER. During CY 2012, HIP members had fewer emergency room visits per 1,000 members than HHW adult members. Additionally, HIP members who were required to make contributions to their POWER accounts visited the ER at a lower rate than those who were not required to make contributions, ESP members, and Hoosier Healthwise members. HIP ESP members likely use the ER at higher rates due to their high-risk conditions.

Table 6.24. Adult Emergency Room Visits, HIP and Hoosier Healthwise, 2012

	Healthy Indiana Plan-ESP	Healthy Indiana Plan-Contributors	Healthy Indiana Plan Non-Contributors	Hoosier Healthwise

Total Members in 2012	2,239	41,329	12,129	203,859
Total number of unique individuals who visited the ER in 2012	992	12,041	4,551	78,194
Percent of unique enrollees who visited the ER in 2012	44%	29%	38%	38%
Total Number of ER Visits, 2012	2,693	22,991	10,541	188,294
Average Visits per Unique Recipient*	2.7	1.9	2.3	2.4
Total Number of Member Months of Enrollment	21,770	360,059	113,174	1,436,641
Average Enrollment (Member months/12)	1,814	30,005	9,431	119,720
Average Number of Months Enrolled	9.7	8.7	9.3	7
Annual Emergency Room Visits per 1,000 members	1,484	766	1,118	1,573

Source: Milliman analysis of 2012 claims, November 2013
*Of those who visited the ER in 2012

2. Emergency Room Usage, As Reported By Members

Among the respondents to the 2013 survey of current HIP members, twenty-eight percent reported that they had made at least one trip to the ER in the six months prior to the survey (Table 6.25). Of those who used the ER, eight percent reported that they had tried to make an appointment with a doctor or clinic, but had not been able to get one fast enough, and chose to go to the ER instead (data not shown). However, the majority of ER care-seekers were not high-frequency users. Of those who used the emergency room, the majority (64 percent) made only one trip, with 22 percent reporting two trips, and only 14 percent reporting three or more trips (Table 6.25).

Table 6.25. Use of Emergency Room In the Past Six Months, Among Current Members (Weighted Data)

Access to ER Care	All Respondents	≤100% FPL	> 100% FPL
Number of members	16,830	11,477	5,353
Percent of members who went to ER in past 6 months	27.8%	27.8%	27.8%
Of those who went to ER in past six months:			

Access to ER Care	All Respondents	≤100% FPL	> 100% FPL
Number	4,670	3,455	1,215
Number of trips made:			
1 trip	64.4%	62.6%	69.5%
2 trips	21.7%	23.9%	16.2%
3 or more trips	13.7%	13.5%	14.3%
Don't know	0.8%	0.0%	1.1%
Number of times admitted to hospital after going to ER			
0 times	72.9%	74.7%	67.9%
1 time	22.1%	20.3%	27.4%
2 or more times	5.0%	5.0%	4.7$
Don't know	0.0%	0.0%	0.0%

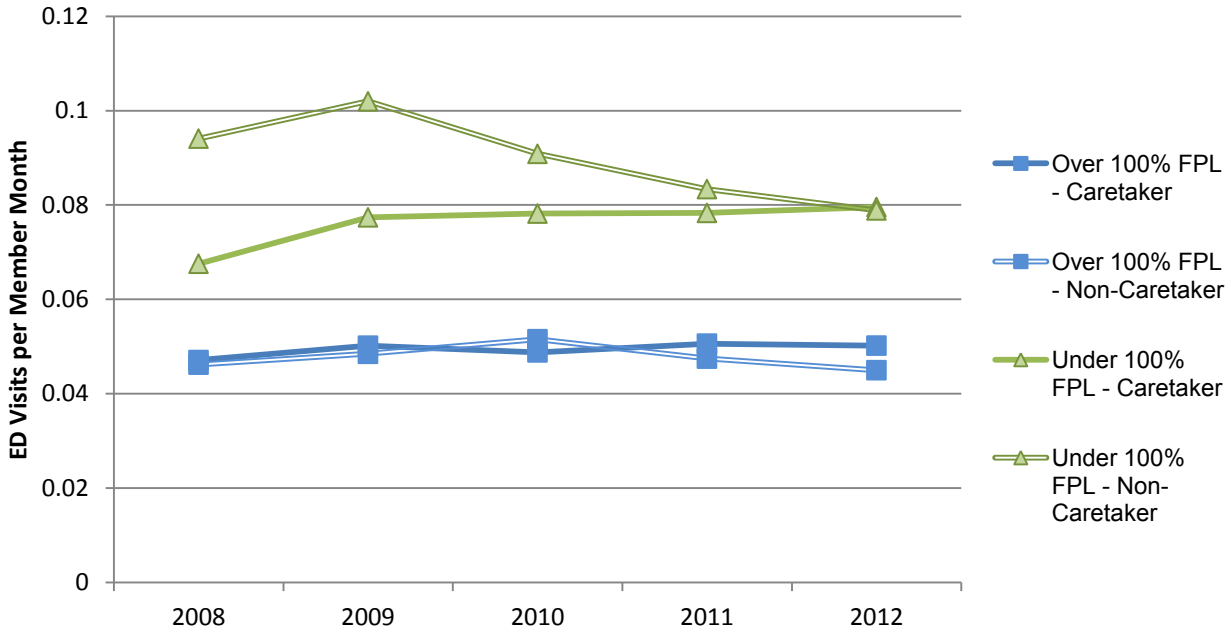
Source: Mathematica analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

4. Self-Reported ER usage trends

Although trends in ER use have been relatively steady throughout the demonstration, several aspects of these trends are notable. As Figure 6.6 indicates, ER utilization rates appear to be associated with income and those in the higher income group consistently throughout the five years of the HIP program used the ER at a lower rate than those in the lower income group. We also see that during the first three years, from 2008 through 2010, the non-caretakers with income at or below 100 percent of FPL first increased and then decreased their use of the ER, eventually having a similar ER use rate as caretakers in the same income group. These data are unadjusted and we cannot rule out the possibility that the changes over time or the differences seen across the different groups are related to differences in case mix; they could also be related to program design and the copay requirements for non-caretakers. These data also do not distinguish between emergent and non-emergent visits and we cannot tell whether the changes are due to changes in non-emergent visits.

Figure 6.6 Rate of Emergency Room Visits Per Member Per Month, 2008 through 2012 (self-reported)



Source: Mathematica analysis of 2013 survey of HIP members.

5. HIP Strategies for Reducing ER Use for Non-Emergent Care: Copayments

In an effort to discourage non-emergent use of the ER and encourage members to seek care from a doctor or clinic, HIP asks members to make a copayment each time they seek care in the emergency room. This copayment is then refunded to caretaker adult HIP members if the visit was later determined to be a true emergency (non-caretakers must make the copay in any case). The majority of respondents (68 percent) reported that they had been informed about the copayment by their health plan, and 5 percent indicated that the copayment had caused them to wait to seek care from a doctor or clinic instead of using the ER (Table 6.26).[15]

[15] Respondents to the 2013 survey of current HIP members were asked the following question, "Has the emergency room co-payment ever caused you to wait to get care from a doctor's office or clinic instead of going to the emergency room?"

Table 6.26. Effect of ER Copayments On Care-Seeking Behavior

Effect of ER Copayments	Total	≤100% FPL	> 100% FPL
Number of members	16,830	11,477	5,353
Percent informed by health plan about ER copayment	67.7%	65.9%	71.6%
Of those informed about copayment:			
Number	11,395	7,561	3,834
ER co-payment caused member to wait to get care from doctor or clinic instead of using ER			
Yes	5.4%	6.0%	4.0%
No	92.7%	92.4%	93.3%
Don't know	1.4%	1.2%	2.0%

Source: Mathematic analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Although representatives from Anthem assumed that hospitals regularly collect HIP co-pays, MHS and MDwise staff expressed uncertainty about whether hospitals chose to collect them, due to the administrative burden of collecting small co-payments. Plans also noted the difficulty inherent in refunding copayments after ER visits were determined to be true emergencies. Overall, about one-third of current HIP members reported they were sometimes or always asked to pay the ER copayment and two-thirds were never asked (Table 6.27). The data do not suggest that Anthem members were more likely to be asked to pay the ER copayment relative to members in other plans, but the information is unreliable due to small samples at the plan level.

Table 6.27. Incidence of Requested ER Copayments, By Health Plan (Weighted Data)

Requested to Pay ER Copayment	Total	Anthem	MDwise	MHS
Total Number of Members	4,670	3,194	1,029	57
Sometimes or always asked to make ER copayment	32.9%	34.5%	26.9%[b]	33.3%[b]
Never asked to make ER copayment	64.5%	63.6%	67.2%	66.7%[b]
Don't Know	2.6%[b]	1.9%[b]	5.9%[b]	0.0%[b]

Source: Mathematic analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Table 6.28. Emergency Room Copayments, By Caretaker Status (Weighted Data)

Emergency Room Copayments	Caretaker	Non-Caretaker
Number of members who went to ER in past 6 months	2,381	2,289
Sometimes or always asked to make ER copayment	27.2%	38.8%
Never asked to make ER copayment	69.3%	59.5%

Don't Know	3.5%[b]	1.7%[b]

Source: Mathematic analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

6. Health Plan Strategies to Reduce ER Use for Non-Emergent Care

In addition to charging co-payments, each of the MCEs also engages in efforts to reduce non-emergent use of the ER.

Anthem

Anthem implemented two different approaches in 2012 to reduce the number of non-emergent ER visits among their HIP and HHW membership. Anthem's first approach utilizes telephone outreach to encourage appropriate use of the ER. As part of the Emergency Room Daily Census Project, five hospitals identify HIP and HHW members with high ER utilization rates. Calls are made to these members within 48 hours of an ER visit to ensure that members were in contact with their assigned PMP and had sought follow-up care from their PMP. The calls also serve to educate members about the appropriate use of the emergency room. In 2012, 9,783 members (HIP and HHW combined) were identified as high ER utilizers; 8,236 calls were made to these members, with 1,897 members successfully reached. Anthem also makes an effort to contact members 3 to 6 months after an ER visit to remind them and to refresh their earlier education efforts.

Anthem's second approach enlists providers to help keep members from using the ER for unnecessary purposes. PMPs are contacted when their assigned member utilizes the ER to ensure the PMPs are aware of these visits. Further, Anthem has contracted with CVS and Walgreen's pharmacy-based clinics and encourages Anthem members to use these clinics rather than the ER. Anthem reports that it is beginning to see a reduction in ER use, and believes that this decline is a result of their accumulated efforts. They could not quantify the size of the reduction.

MDwise

MDwise's ER initiative is based on information it gets from the Indiana Health Information Exchange (IHIE). The IHIE receives notifications of emergency department (ED) visits on a daily basis from five hospitals in Marion County. ED visits for MDwise members are forwarded to the plan for followup. A registered nurse at MDwise triages all notifications and identifies those with non-urgent symptoms. The nurse assigns a portion of these cases to care management for followup and the remaining are referred for followup by an automated call system.

For the automated call system, MDwise contracts with a vendor that receives a list of those members selected for the call followup. The vendor attempts to contact each member on the list at least three times, within two to four weeks of the ED visit. Once reached, the vendor follows an approved script. The script advises the member that MDwise is following up after an ED visit and identifies the date(s) of the visit. The call is interactive, requiring the member to answer a

question about whether they called their doctor prior to going to the ED. It reminds the member of the plan's 24-hour nurse line and the importance of calling their provider who is available 24/7, to answer their questions. MDwise has been conducting these calls since 2010.

MDwise has studied the effectiveness of these calls with their HHW membership. For calls in 2010, they compared ED visits six months before and six months after the automated call system began. The control group was made up of those members who also had ED visits within the same time period and were referred for the automated call intervention, but were never successfully contacted by the system. MDwise assessed the number of provider office visits six months before the intervention and six months following the intervention and found that ED visits following the introduction of the automated call system were 8.2 percentage points lower for the successful call group compared to the control group. They also saw a corresponding increase (10.2 percentage points) in the number of provider office visits following the introduction of the automated calls. Both differences were statistically significant with $p < .0026$.

In 2011, MDwise expanded this intervention to include their HIP members. Due to the low number of members in the HIP program and subsequent low numbers referred for a call, MDwise has not conducted a similar type of data analysis as they did with their HHW membership. For HIP, MDwise automated call system had the following number of contacts.

- In 2011, MDwise referred 109 HIP members to the automated call system, the system was able to reach 41 members, and of those reached, 51 percent indicated that they had called the PMP prior to the ED visit.
- In 2012, MDwise referred 27 HIP members to the automated call system, the system was able to reach 11 members, and of those reached, 27 percent indicated that they had called their PMP prior to the ED visit.

MDwise also reports that in 2013, MDwise will receive ED reports from more hospitals through the IHIE and these additional hospitals will be from across the entire state of Indiana. They anticipate this change will increase the number of referrals for HIP members.

MHS

MHS case managers receive "ER Bounce Back Reports" detailing information for HHW and HIP members who utilize the ER. Members who are noted to have high rates of ER use are contacted by staff that provide education and check whether the member is enrolled in MHS' case management program. If so, case managers will work with the member to identify root causes of high rates of ER use. During 2012, 58 HIP and HHW members were identified as frequent ER users and were engaged by case managers for this initiative.

In the past, MHS tried to educate its members on proper ER use with an auto-dial program that gave enrollees the option to talk to a case manager. In 2012, MHS' case managers began making proactive calls to members and were able to speak with more people about appropriate ER use. This MCE reported a reduction in ER use, although like Anthem, could not provide concrete data.

6.4 GOAL IV – PROMOTE PRIMARY PREVENTION

HIP encourages the use of preventive services by allowing members to obtain the first $500 worth of services without having to draw on their POWER account funds[16]. It also ties POWER account rollovers, and reductions in future monthly contributions, to the completion of required preventive care.

To determine whether HIP has promoted the use of primary preventive services, the analyses below assess general patterns of preventive care use among different groups of HIP members, using the criteria that the health plans and the State used in the POWER account reconciliation process for members who started eligibility periods in 2009 and beyond – completion of a well physician office visit or any of the age-appropriate preventive services recommended by the State (and listed in Table 6.28).

In addition, Mathematica's 2013 survey of current members asked respondents about their receipt of preventive care and their overall knowledge of preventive care policies. Survey questions asked current members about the length of time since they had received a routine check-up, their knowledge of the preventive services that HIP wanted them to receive, and their plans to obtain these preventive services before the end of their benefit period.

Findings include:

- Women are far more likely than men to receive at least one preventive care service. Among both women and men, the likelihood of receiving at least one service increases with age.
- Members required to contribute to the POWER account receive preventive care at higher rates than those not required to contribute to the POWER account.
- Individuals at or below 100 percent of the FPL are slightly less likely to receive at least one preventive care service compared to those at higher income levels.
- Though 85 percent of survey respondents reported receiving a "routine check-up" in the past year, Milliman's assessment of HIP claims records indicate that 35 percent of current members received a general physical exam within 2012. This discrepancy may be due to a difference in how members perceive a "routine check-up," versus how HIP or physicians may code for their services in a billing record.
- Forty-two percent of members knew that their health plan wanted them to get preventive services, though this number was higher among those above 100 percent FPL as compared to members at or below the FPL.

[16] MDwise and MHS both allow their members to receive unlimited preventive care services, without any amount being deducted from their POWER accounts. Anthem, however, has a $500 limit allowed by the program.

A. RECEIPT OF PREVENTIVE SERVICES

Beginning in 2009, the state required a well physician office visit or completion of any of the seven priority preventive services specified by the State for a POWER account rollover (Table 6.29).

Table 6.29. HIP Preventive Care Services, 2012

	Men			Women		
Preventive Care Service	19-34	35-49	50-64	19-34	35-49	50-64
Annual Physical	X	X	X	X	X	X
Cholesterol Testing		X	X		45+	X
Blood Glucose Screen	X	X	X	X	X	X
Tetanus-Diptheria Screen	X	X	X	X	X	X
Mammogram					X	X
Pap Smear				X	X	X
Flu shot			X			X

Source: Indiana OMPP. "Health Indiana Plan: Coverage for Preventive Services 2008-2009, Full POWER Account Rollover." Revised August 2009.

Note: Preventive care requirements have not changed since 2009

To assess receipt of preventive services among HIP members, encounter records submitted by the health plans were analyzed. A composite measure of preventive services receipt was constructed that utilized encounter records for inpatient, outpatient, and physician office services from February 2009 to December 2012. Table 6.30 lists the codes that were considered evidence of service receipt for each of the seven services considered. The analysis assessed whether each member had *any one* of the services appropriate for his or her age and gender and that were recommended from 2009 onwards.

Table 6.30. Designated Procedure/Diagnosis Codes for Receipt of Priority Preventive Services in 2012

Preventive Service	Designated Procedure Codes	Diagnosis Code Required to Accept Procedure Code
Preventive Care Visit	99385-99387 99395-99397 99401-99404	None
	99201-99205 99211-99215	V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 Women only: V72.3, V72.31, V72.32, V76.2
Breast Cancer Screening	77057 77052 (with 77057) 77055 77056 77051 (with 77055 or 77056)	None
Pap Smear/Cervical Cancer Screening	88141-88155 88164-88167 88174-88175	None

	88150-88154	
	88164-88167	
	88142-88143	
	G0101	
	G0123-G0124	
	G0141	
	G0143-G0145	
	G0147-G0148	
Cholesterol Screening	83718	None
	83719	
	83721	
	82465	
	84478	
Blood Glucose Screening	V77.1	
	83036-83037	
	82945	
	82947	
	82950-82953	
	G8015-G8026	
Tetanus-Diphtheria	90715	None
	90714	
	90718	

The receipt of preventive services was examined over three years of the demonstration: 2010, 2011, and 2012. Each year includes preventive services information for all benefit periods which ended during that year. For example, the year 2010 includes 12 benefits periods (February 2009-January 2010, March 2009-February 2010, etc).

Between 2010 and 2012, rates of preventive services receipt remained the same or rose slightly among all groups except for females ages 19-34 (Table 6.31). Overall, the likelihood of receiving at least one preventive service increased with age, but women were far more likely than men to receive preventive care (69 percent versus 39 percent in 2012).

Table 6.31. Preventive Services Receipt Among HIP Enrollees, 2010-2012

Receipt of Preventive Services	2010	2011	2012
Overall (across entire HIP population)	56%	57%	60%
Contributors	57%	58%	61%
Non-Contributors	51%	53%	53%
Males			
All Ages	34%	35%	39%
Ages 19-34	23%	23%	30%
Ages 35-49	35%	36%	38%
Ages 50-65	47%	51%	53%
Female			
All Ages	68%	68%	69%
Ages 19-34	64%	63%	63%

Receipt of Preventive Services	2010	2011	2012
Ages 35-49	68%	68%	70%
Ages 50-65	73%	75%	78%

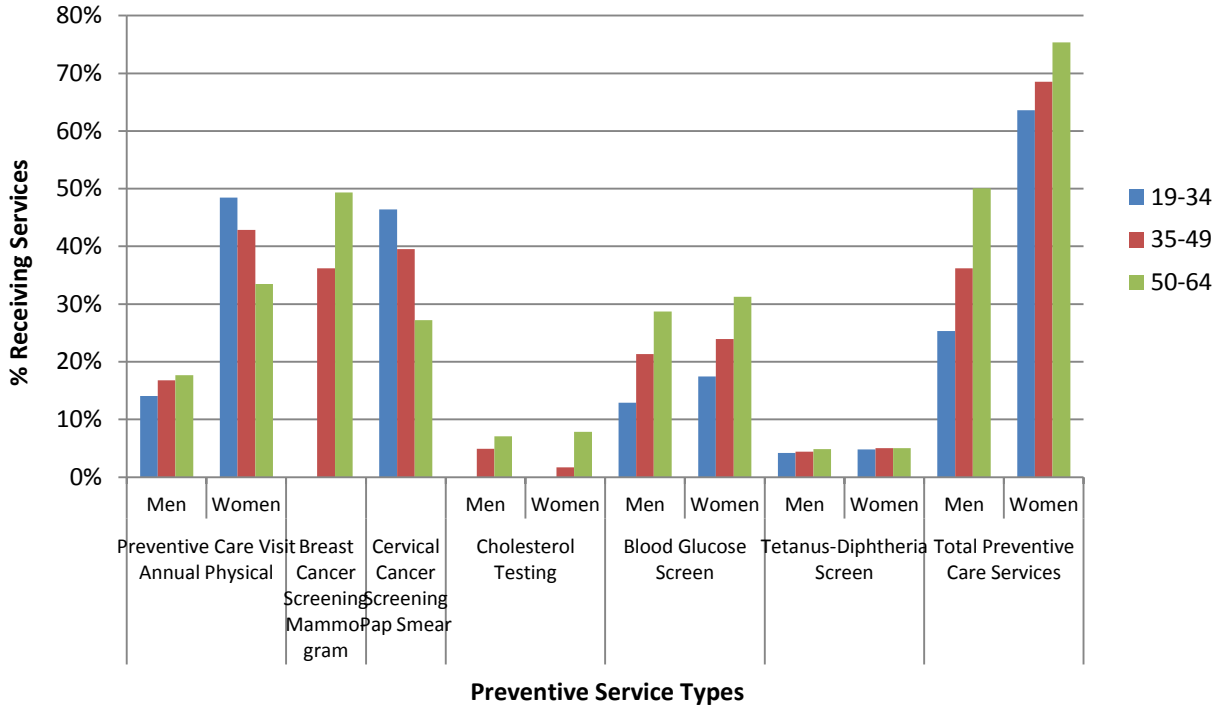
Source: Milliman analysis of preventive care receipt.
Note: Rates above were developed using administrative data only. A chart review would likely show higher rates, as it would include individuals who received preventive care services that were not billed separately but provided as a part of an office visit. In addition, enrollees may have received preventive care as part of an outreach effort, such as a flu vaccination drive, that was not captured in the administrative data.

The HIP program's design creates a financial incentive for its members to receive preventive care. If any State-contributed funds remain in a member's POWER account at the end of the calendar year and he or she has received at least one recommended preventive service, the money carries over to help fund the next year's deductible. This effectively reduces the amount of the member's monthly contribution in the next year.

The majority of HIP members are required to make contributions to their POWER accounts, but some (just under 25 percent in 2012) are exempt due to a lack of income or CMS income counting rules. For these individuals, the State funds the entire $1,100 POWER account contribution. This circumstance creates a comparison group between the group that has a financial incentive to receive preventive services and reduce future monthly contributions and the group that makes no contributions. The HIP design appears to encourage use of preventive care among those who make contributions. Claims data shows that HIP members required to make POWER account contributions received preventive care at higher rates than those who were not required to make POWER account contributions. In 2012, 61 percent of HIP members who were required to contribute to their POWER accounts received at least one recommended preventive service, while only53 percent of those not required to make POWER account contributions received preventive care (Table 6.31).

Though the likelihood of receiving at least one preventive care service increased with age, variations were observed between men and women and across specific services (Figure 6.7). While older men (ages 50-64) were slightly more likely than younger men (ages 19-34) to receive an annual physical, the reverse was true among women. Women ages 50-64 were more likely than younger women to receive a mammogram, but less likely to receive a pap smear/cervical cancer screening. Among both men and women, rates of cholesterol testing and blood glucose screening increased with age. Tetanus/diphtheria screening was rare among both men and women, with little or no variation observed by age group.

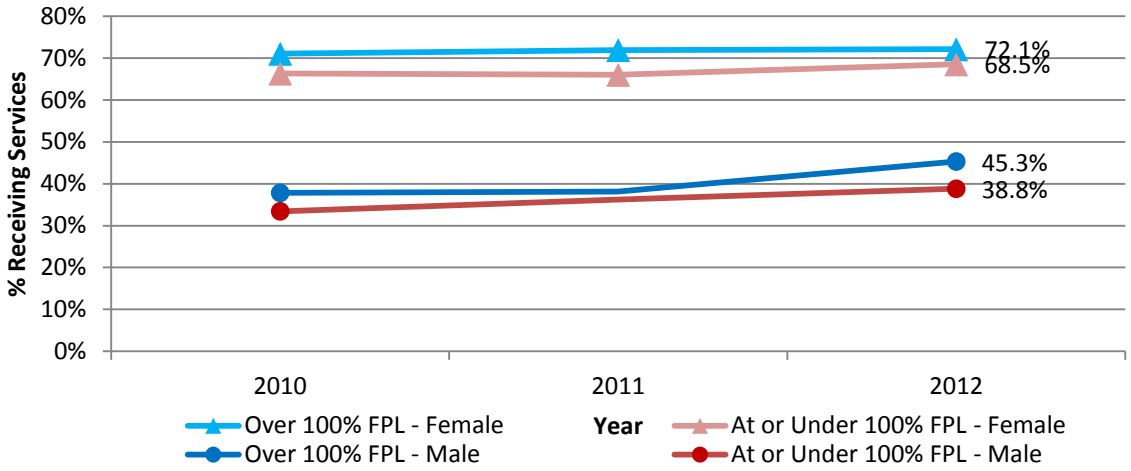
Figure 6.7: Type of Preventive Services HIP Members Received, 2012



Source: Milliman analysis of preventive care receipt.

In 2012, 72 percent of women at or above 100 percent FPL received preventive care services, while 69 percent of those below the FPL did so. The difference among men was slightly larger, with 45 percent of men at or above 100 percent FPL and 39 percent below FPL received preventive services in 2012.

Figure 6.8: Trends in Preventive Services Receipt, 2010-2012



Source: Milliman analysis of preventive care receipt.

2. Self-Reported Use of Preventive Services

The majority of respondents to Mathematica's 2013 survey – 85 percent – reported receiving a routine check-up within the year before the survey (Table 6.32).[17] Among those who reported not receiving a check-up in the past 12 months, nearly a quarter (23 percent) reported that the routine check-up was unnecessary (data not shown). Other prevalent reasons included not having time, not wanting to go, or feeling it was not needed because the respondent already received regular treatment for an ongoing medical condition. Notably, the analysis of claims records by Milliman suggests that 35 percent of current members received a general physical exam within 2012 (data not shown). The discrepancy between self-reported information and claims records may be due to a difference in how members perceive a "routine check-up," versus how HIP or physicians may report or code this type of care in a billing record.

Table 6.32. Routine Check-ups (Weighted Data)

Length of Time Since Routine Check-Up	All respondents	≤100% FPL	>100% FPL

[17] Respondents to the survey of current HIP members were asked how long it had been since they had visited a doctor for a routine check-up, defined as "a general physical exam, not an exam for a specific injury, illness, or condition."

Length of Time Since Routine Check-Up	All respondents	≤100% FPL	>100% FPL
Total number	16,830	11,477	5,353
Within past 3 months	37.9%	39.4%	34.7%
Within past year	46.7%	44.7%	51.0%
Within past 2 years	8.5%	9.4%	6.5%
2 or more years ago	6.5%	6.0%	7.5%
Don't know	0.4%[b]	0.3%[b]	0.4%[b]

Source: Mathematica analysis of 2013 survey of HIP members.

Note: Response options were mutually exclusive groupings.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

B. HEALTH PLAN STRATEGIES TO PROMOTE PREVENTIVE CARE

Anthem, MDwise, MHS, and the ESP administrator have promoted the use of preventive services through mailings, newsletters, telephone and other outreach, and a number of incentive programs.

1. Outreach Through Telephone, Mailings, and Newsletters

Anthem

Each new HIP member who enrolls in Anthem receives a welcome call from a Health Needs Specialist to inform them about plan benefits, including preventive care. During the call, the member is given the opportunity to select a PMP. Anthem members also receive customized MyHealth Notes, which remind members to get regular preventive care, encourage the correct use of prescription drugs, and promote overall wellness.

MDwise

MDwise mails letters to all new members explaining the importance of preventive care and the need to complete the preventive care requirements to secure a full POWER account rollover. MDwise also mails monthly POWER Account invoices and statements that provide a listing of all health care services the member has used in the past year.

MHS

During 2012, MHS focused its outreach resources on online publications, and utilized a number of platforms to encourage preventive care and educate members about plan benefits. Sixty-five items were published online to educate HIP and HHW members on various topics, including nutrition, fitness, and general benefit information. These efforts included a series of posts called "Quick Tips for HIP," which reminded members about the benefits of receiving preventive care and other relevant topics. All of the posts were made available on the MHS Web site and on Facebook and Twitter.

During its March 27 Madison County Health Center Diabetic Day/Health Check Health Day, MHS attempted to get HIP and HHW members who had not received their required preventive care in to see their PMP. For the event, MHS contacted members whose claims history indicated they were due for one or more recommended preventive services, and invited those members to see their PMP for a check-up and needed screenings..

2. Incentive Programs

All three plans encourage members to complete a Health Risk Assessment (HRA) through incentives described below.

Anthem

In 2012, Anthem introduced a new incentive program targeting members who approach the end of their benefit period without having received the recommended preventive services. These members are offered a $50 gift card contingent upon receipt of these services within the benefit period. In 2012, mailers were sent to qualifying members encouraging diabetes, breast cancer, and cervical cancer screenings. Breast cancer screening mailers were sent to 2,119 HIP members, 11.1 percent of whom returned the form to claim the gift card, while diabetes screening mailers were sent to 1,840 members (with 10.2 percent claiming the reward), and cervical cancer screening mailers were sent to 4,880 members, with 7.9 percent receiving the incentive.

During Anthem's welcome calls, new members are encouraged to complete an HRA and are offered incentives to do so. Those who complete an HRA online receive a $20 CVS gift card, while those who complete it over the phone receive a $10 card (with a limit of one per household). In 2012, 2,673 HIP members completed an HRA.

MDWwise

The MDwiseREWARDS program uses incentives to encourage members to seek preventive care. Members earn points that can be redeemed for a gift when they complete a HRA, visit the doctor for an annual exam and health screening, or register to receive monthly statements online. MDwise promoted the incentive program in its main brochure, member handbook, on its Web site, and through postcards mailed to all members. Several of these promotion efforts proved successful in increasing the program's reach. In December of 2012, a mailing was sent to all HIP/HHW households, after which the REWARDS Web site saw a 206 percent increase in unique pageviews, and there was a 313 percent increase in HIP member gift card redemption. MDwise also created a business card-sized promotional card for providers to hand out to members. After use of the card began, MDwise REWARDS saw a 50-100 percent increase in gift card redemptions.

MHS

MHS has created the CENT-Account Rewards program that provides incentives for various activities. Incentive money is loaded directly onto the member's HIP debit card and can be used to purchase health supplies or pay co-pays. Members can receive $10 for visiting their assigned PCP within the first 90 days of MHS membership. In 2012, a new incentive was added in which members can receive $30 for completing a telephone HRA within the same time period. Of MHS members who maintained at least 90 days of coverage and could be contacted during that period, 49 percent completed a new member health screening.

C. MEMBER KNOWLEDGE AND EFFECTS OF HIP PREVENTIVE CARE POLICIES AND OUTREACH

Many current HIP members knew their health plan wanted them to get preventive care and reported either getting the care or planning to get preventive care services before their next renewal period. When asked by Mathematica's 2013 survey, 42 percent of current HIP members knew that their health plan wanted them to get preventive services, though this number was higher among those above 100 percent FPL as compared to members at or below the FPL (48 percent versus 39 percent) (data not shown).

Of those who knew their health plan wanted them to get preventive services, 80 percent reported that they had been encouraged by their health plan by letter, email, or phone call to receive preventive care (Table 6.33). Some variation was observed by health plan, with Anthem members more likely than MDWise members to report having been contacted by their plan about preventive care (83 percent versus 74 percent) (data not shown). Overall, 60 percent of these members said they had received at least one preventive service since their last renewal. Of those who had not, 78 percent said they planned to get them before their next renewal. Most of those individuals who did not plan to get these services reported that they felt it was unnecessary, did not have time to go, or did not want to go (data not shown).

Table 6.33. Preventive Care Knowledge and Self-Reported Receipt of Preventive Services (Weighted Data)

Preventive Care Knowledge and Receipt	Members Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100% FPL
Number of members	7,013	4,443	2,570
Knew that health plan wanted them to get:			
Blood Glucose Screen	60.2%	56.9%	65.8%
Cholesterol Screen	65.2%	61.4%	71.9%
Flu shot	61.4%	57.6%	67.9%
Mammogram[a]	58.4%	54.9%	64.6%
Pap Test/Pap Smear[a]	61.3%	58.3%	66.5%
Routine physical exam	84.4%	85.3%	83.0%
Tetanus shot	30.2%	29.0%	32.4%
Other service	6.6%[b]	7.5%[b]	5.2%[b]
Don't know	1.5%[b]	0.5%[b]	3.2%[b]
Have been encouraged by health plan via letter, email, or phone call to get preventive			

Preventive Care Knowledge and Receipt	Members Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100% FPL
care			
Yes	79.7%	78.6%	81.7%
No	18.6%	20.1%	16.1%[b]
Don't know	0.8%[b]	0.4%[b]	1.5%[b]
Have gotten any of these services since last annual renewal			
Yes	59.5%	59.5%	59.4%
No	37.3%	38.2%	35.8%
Don't know	3.3%[b]	2.3%[b]	4.9%[b]
Of those who have not gotten services since last annual renewal:			
Number	2,616	1,696	919
Plan to get services before next renewal			
Yes	78.3%	77.2%	80.4%
No	14.0%[b]	13.3%[b]	15.3%[b]
Don't know	3.8%[b]	5.9%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of HIP members.

[a]All respondents were asked whether their health plan wanted them to get the services listed, including mammograms and pap test/pap smears. The percentages of people who accurately reported that their health plan wanted them to get these two services is therefore underreported, because the denominator includes men.

[b]These estimates may be unreliable because they are based on fewer than 30 respondents.

Having an awareness that the plan wanted them to get services does not appear to have an effect on a member's likelihood to report having received services since the last renewal. Sixty percent of individuals in both groups – those aware and those unaware that their plan wanted them to get preventive services – reported that they had received services since their last renewal. Of those who were unaware that their health plan wanted them to get services and had not already done so, 64 percent said they planned to get preventive care before their next renewal (Table 6.34).

Table 6.34. Preventive Care Receipt Among Current Members Not Aware That Their Health Plan Wanted Them To Get Preventive Services (Weighted Data)

Preventive Care Receipt	Members Not Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100%FPL
Number of members	9,798	7,015	2,798
Have been encouraged by health plan via letter, email, or phone call to get preventive care			
Yes	29.4%	27.1%	35.1%[b]

Preventive Care Receipt	Members Not Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100%FPL
No	67.3%	70.0%	60.5%[b]
Don't know	0.6%[b]	0.6%[b]	0.8%[b]
Have gotten any of these services since last annual renewal			
Yes	60.4%	59.0%	63.1%[b]
No	34.5%	37.7%	28.5%[b]
Don't know	2.9%[b]	3.3%[b]	2.1%[b]
Of those who have not gotten services since last annual renewal:			
Number	1,056	756	299
Plan to get services before next renewal			
Yes	63.7%	57.4%	79.7%[b]
No	25.0%[b]	32.1%[b]	7.0%[b]
Don't know	11.3%[b]	10.5%[b]	13.3%[b]

Source: Mathematica analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

6.5 GOAL V - PREVENT CHRONIC DISEASE PROGRESSION WITH SECONDARY PREVENTION

By lowering cost and access barriers to care and encouraging members to be more engaged patients, HIP aims to slow disease progression among members with chronic conditions. Detecting the extent to which HIP is slowing the progression of chronic disease is extremely difficult and the data currently available do not provide a clear answer. The following analyses used diagnosis codes found on HIP service records to assess the occurrence of different categories of chronic conditions and used health plan reports to document ways in which the MCEs are helping members manage chronic conditions.

Analyses indicate that:

- Chronic disease is prevalent among members, and approximately 30 percent of HIP members had three or more chronic conditions (Table 6.35). The most common chronic conditions in 2012 were cardiovascular, psychiatric, skeletal and connective, and gastrointestinal. As in past years, non-caretakers were more likely than caretakers to be diagnosed with chronic disease.
- All three MCEs provide disease management programs to help members manage chronic conditions, but none offered participation incentives in 2012.

A. PREVALENCE OF CHRONIC CONDITIONS

To assess the prevalence of chronic conditions among HIP members, the Chronic Illness and Disability Payment System (CDPS) algorithm was applied to inpatient and outpatient encounter records of those enrollees with 6 or more months of enrollment in HIP during 2012. The CDPS is a diagnostic classification system developed to describe different burdens of illness among Medicaid beneficiaries. Using ICD-9 codes, the CDPS categorizes diagnoses into 20 major categories, which correspond to body systems. Each of the major categories is subdivided according to the degree of increased expenditures associated with the diagnosis. The CDPS analysis was supplemented with the Medicaid Rx (MRx) algorithm, which was designed to identify chronic conditions among beneficiaries who receive pharmacotherapy but do not have a qualifying CDPS diagnosis in their encounter records.

Chronic disease was prevalent among HIP members, which may partly explain why many members exhaust their POWER account funds and are not eligible for POWER account rollovers. Among those enrolled in HIP for at least six months during 2012, the most common chronic conditions classified by the CDPS algorithm were cardiovascular (32.3 percent), psychiatric (23.8 percent), skeletal and connective (20.1 percent), and gastrointestinal (19.0 percent) (Table 6.34). Non-caretakers were much more likely than caretakers to have chronic conditions, which is consistent with the differences in demographic characteristics and that non-caretakers tend to be older than caretakers (see Table 6.1).

The MRx algorithm identifies an additional 7.4 percent of members who were treated with medications for cardiovascular conditions, but did not have an inpatient or outpatient visit with a cardiac diagnosis. Similarly, it flagged more than 40 percent of HIP members as having a psychiatric condition; 23.8 percent were identified as having a psychiatric diagnosis on an encounter record and an additional 16.7 percent were identified in this group because they filled a prescription for a psychotropic medication during 2012.

Table 6.35. Percent of HIP Enrollees with 6+ months of enrollment in 2012 with Chronic Conditions

Category	All HIP Members N=42,986	HIP Caretakers N=27,408	HIP Non-Caretakers N=15,578
CPDS			
Cardiovascular	32.3%	24.5%	46.0%
Psychiatric	23.8%	23.1%	25.1%
Skeletal and Connective	20.1%	17.0%	25.4%
Gastrointestinal	19.0%	16.3%	23.6%
Pulmonary	16.1%	13.1%	21.4%
Diabetes	12.9%	9.5%	18.8%
Ear	10.3%	10.4%	10.2%
Nervous System	8.1%	6.6%	10.7%
Skin	6.7%	6.1%	7.8%
Metabolic	5.9%	4.8%	7.9%
Genital	5.2%	5.6%	4.4%
Substance Abuse	4.6%	3.4%	6.9%
Renal	3.6%	2.7%	5.0%
Infectious Disease	2.9%	2.1%	4.3%
Eye	2.2%	1.0%	4.4%
Cancer	8.9%	7.5%	11.4%
Hematological	1.2%	1.0%	1.6%
Cerebrovascular	0.6%	0.4%	1.0%

Category	All HIP Members N=42,986	HIP Caretakers N=27,408	HIP Non-Caretakers N=15,578
Developmental Disability	0.1%	0.0%	0.1%
MRx			
Psychosis/Bipolar/ Depression	16.7%	16.0%	17.9%
Cardiac	7.4%	7.0%	8.2%
Seizure disorders	2.8%	3.0%	2.4%
Anti-coagulants	1.2%	1.1%	1.5%
Diabetes	1.3%	1.4%	1.2%
Malignancies	1.0%	0.9%	1.2%
Parkinsons / Tremor	0.8%	0.6%	1.2%
Inflammatory /Autoimmune	0.3%	0.3%	0.3%
Infections, high	0.2%	0.2%	0.2%
Hepatitis	0.2%	0.1%	0.3%
Tuberculosis	0.1%	0.1%	0.1%
HIV	0.0%	0.0%	0.0%
ESRD / Renal	0.0%	0.0%	0.0%
Multiple Sclerosis / Paralysis	0.0%	0.0%	0.0%
Hemophilia/von Willebrands	0.0%	0.0%	0.0%

Source: Milliman, Inc, May 16, 2013.

Multiple diagnoses were common. Approximately 30 percent of HIP members had three or more chronic conditions. However, most of these diagnoses reflected low-cost conditions. Considering only subcategories associated with medium or higher costs, only 1.6 percent had three or more CDPS diagnoses.

For all CDPS categories except genital conditions, prevalence among non-caretakers was higher than among caretakers, often by substantial margins (Table 6.35). For example, 46 percent of non-caretakers had cardiovascular conditions, compared to 25 percent of caretakers. Indeed, about one-third of caretakers had no CDPS chronic condition, compared to only 21 percent of non-caretakers (Table 6.35). The differences between groups persist when only medium- and high-cost conditions were considered. About thirty percent of non-caretakers were diagnosed with at least one higher-cost condition, as compared to 20 percent of caretakers. These patterns are summarized by each group‘s average CDPS risk score, which is a summary index of the relative expected medical costs for each member given their identified chronic conditions. The CDPS risk score for the population as a whole is 1.00. The average score among caretakers was 0.84, indicating that as a group they are expected to be 16 percent less costly than the HIP average. The average score among non-caretakers was 1.27, indicating that as a group they are expected to be 27 percent more costly than the HIP average. See Table 6.35.

Table 6.36. Chronic Illness and Disability Payment System (CDPS) Risk Score and Number of Conditions Identified, by Enrollee Group, HIP Members 2012

				All CDPS Identified Conditions, Percent with:			CDPS Identified Conditions with "Medium" or Greater Expected Cost Impact: Percent with:		
Characteristics	HIP Members	Scored HIP members	Normalized CDPS Risk Score	No Conditions	1-2 Conditions	3 or More Conditions	No Conditions	1-2 Conditions	3 or More Conditions
All HIP Members	55,701	42,986	1.00	29.1%	41.2%	29.7%	76.8%	21.6%	1.6%
HIP Caretakers									
All	38,190	27,408	0.84	33.9%	42.5%	23.6%	80.2%	18.8%	1.0%
19-34	13,050	8,544	0.70	39.9%	43.0%	17.2%	83.2%	16.4%	0.4%
35-49	20,409	15,166	0.86	33.1%	42.3%	24.5%	80.1%	18.8%	1.1%
50-64	4,671	3,668	1.07	23.5%	41.7%	34.8%	73.5%	24.4%	2.1%
65+	60	30	1.24	23.3%	50.0%	26.7%	73.3%	23.3%	3.3%
HIP Non-Caretakers									
All	17,511	15,578	1.27	20.6%	38.9%	40.5%	70.9%	26.5%	2.6%
19-34	2,440	2,098	0.88	37.0%	41.6%	21.4%	79.6%	19.4%	1.1%
35-49	4,785	4,252	1.34	20.6%	37.1%	42.2%	69.7%	27.6%	2.6%
50-64	9,798	8,964	1.31	16.6%	39.2%	44.2%	69.3%	27.7%	3.0%
65+	488	264	1.39	22.4%	36.4%	41.3%	73.1%	22.0%	4.9%

Source: Milliman, Inc, May 16, 2013.

Note: Scored members had at least 6 months of HIP eligibility. For Normalized CDPS Risk Score, Concurrent Risk scores were used, weighted by HIP Member Months. Table excludes "not well defined" and "super low" CDPS flags. Percentages may not add to 100 due to rounding.

B. HEALTH PLAN MANAGEMENT OF CHRONIC CONDITIONS

The health plans provide support to their members with chronic conditions primarily through focused disease management programs, which use a telephone-based case management approach to help these members manage their health.

1. Disease Management

All three plans participate in Right Choices, a care management program for members with unusually high service utilization, particularly of emergency room and prescription drug services. This program limits the pharmacies, providers, and hospitals where the member may receive care, while also providing outreach services from care managers at each plan. In addition, Anthem, MHS, and MDwise all offer disease management programs for members identified as having certain chronic conditions.

The MCEs reported that consolidating their HIP and HHW call centers increased their ability to provide disease management services. Plan representatives noted that if a person enrolled in either HHW or HIP placed a call to the call center, staff could view the records of the person's entire family. They could note if someone in the family was enrolled in a disease management program but had not recently received services, and immediately transfer the member to a case manager.

Anthem

Anthem's disease management program, known as 360 Condition Care, is available for members with medium- to high-risk asthma, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), diabetes, end stage renal disease (ESRD), and chronic kidney disease (CKD). The plan analyzes its service records to identify members with these conditions, rate their risk, and refer them to the disease management program when appropriate. Members with medium- and high-risk conditions are assigned to case managers, who provide clinical support by connecting patients to providers, goal setting, offering help keeping appointments, and offering strategies to help the member adhere to physician instructions. In 2012, Anthem continued offering disease management services to all members diagnosed with one of its identified conditions, but began targeting members who were diagnosed with a condition and were identified as experiencing a clinical gap in care (such as, members diagnosed with diabetes who had not received the recommended blood glucose test).

In 2012, Anthem's asthma and diabetes programs were the largest in terms of number of enrollees as compared to other programs, though enrollment in all disease management programs decreased during the year. Anthem reported that 78 enrollees in its CAD program received cholesterol screenings during 2012. Of those in its diabetes program, 142 received a hemoglobin A1C screen, 99 received kidney disease monitoring, 176 received cholesterol screening, and 335 received a retinal exam.

Enrollment in Anthem's chronic disease management programs decreased over the year. A small percentage of the decrease can be attributed to graduation from the program. However, the majority of the decrease was due to program dropout or the inability of Anthem staff to contact the member due to an incorrect phone number.

Table 6.37. Anthem's Disease Management Programs

Disease Management Program	Members Enrolled January 1, 2012	New Members Enrolled During 2012	Members Enrolled December 31, 2012	Percent change during 2012
Asthma	2,201	196	1,236	-43.8%
CAD	57	7	36	-36.8%
Heart Failure	235	54	117	-50.2%
COPD	1,615	94	870	-46.1%
Diabetes	2,664	282	1,381	-48.2%

Source: Anthem, 2012.

Note: More limited data were available for those in the ESRD and chronic kidney disease disease management programs. Three individuals were identified as having ESRD in 2012, and 2 were placed in case management. Four individuals were identified as having CKD, and 1 was placed in case management.

Anthem also offers a Depression Program, which conducts outreach to members who began taking medication for depression. This program sends members personalized health information brochures containing information on depression medication, as well as the importance of medication adherence. Members in the program also receive automated calls when they began taking their medications, and regular calls afterward to remind them to refill their prescriptions.

MDwise

MDwise's disease management program is known as INcontrol. It uses a case management approach to help certain members at higher risk manage their chronic conditions. The six diseases managed in the program include asthma, diabetes, congestive heart failure, coronary artery disease, chronic kidney disease, and chronic obstructive pulmonary disease.

Table 6.38 . MDWise INControl Program Enrollment, 2012

INControl Program	Members Enrolled
Asthma	432
Diabetes	452
Congestive Heart Failure	102
CAD	101
Chronic Kidney Disease	6
COPD	479

Members are identified and referred to this program when they complete the Health Needs Assessment at enrollment and annually at re-enrollment. They may also be referred by a provider, or through a call to the health plan. Those referred receive educational materials about their disease and access to case management services. MDwise also offers information to members on its WEIGHTwise and SMOKEfree programs.

MDwise focuses its outreach by sending provider outreach teams to meet with HIP providers and discuss the HEDIS quality measures. Occasionally, teams will also hold meetings with groups of providers to discuss specific disease management topics.

MHS

In 2012, MHS offered disease management programs for members with asthma, diabetes, catastrophic/trauma/multiple co-morbidies/transplant care, coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, depression, and bipolar disorder. To enroll members in its disease management programs, MHS examines encounter data to identify high-risk individuals with one or more of the selected conditions. In addition, the plan sends representatives to meet with HIP providers and encourage them to refer appropriate individuals to the disease management programs.

Table 6.39 . MHS Disease Management Program Enrollment, 2012

Disease Management Program	Members Enrolled
Asthma	18
Diabetes	2
CAD	1
COPD	1
Depression	113
Bipolar	53

In September 2011, MHS also introduced a pilot obesity/weight management pilot program. Candidates for this program are identified based upon BMI, co-morbidities, and willingness to address weight-related behaviors. Participants are provided with a coach, who offers nutritional counseling, education about exercise programs, and ongoing support. The 28 participants who have enrolled in the program have remained enrolled for an average of 158 days. Slightly more than half (54 percent) experienced weight loss, with an average weight loss of 17.8 pounds. Members are asked to show continued active commitment to the plan of care, and can remain enrolled as long as they are actively participating and showing progress. At the point when it is evident that they are no longer engaged in the process, they are disenrolled from the program.

In August of 2012, MHS began to augment its asthma and diabetes programs to transform them into “higher touch” programs. Rather than simply sending newsletters to members in these

programs, it began making outbound calls to assess each person's needs and provide a higher level of personal attention.

2. Incentive Programs for Disease Management

None of the plans offer incentives for participation in disease management programs.

6.6 GOAL VI – PROVIDE APPROPRIATE AND QUALITY-BASED HEALTH CARE SERVICES

A critical goal for HIP is to provide appropriate and quality-based health care services. Although the State is ultimately responsible for ensuring the quality of services delivered to HIP members, much of the day-to-day responsibility rests with the contracted MCEs: Anthem, MDwise, and MHS. The analyses that follow use a number of data sources to evaluate the MCEs' ability to provide quality health care services, including (1) plan performance information abstracted from a March 2013 report completed by Burns & Associates, Inc., the program's external quality review organization (EQR); (2) member experience with care data gathered from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data that the health plans submit to the State (these CAHPS surveys were of HIP members only, not the plans' other Medicaid, commercial, or Medicare populations); and (3) satisfaction information Mathematica collected in 2013 through a survey of current HIP members; and (4) aggregate data on inquiries reported by the State.

Findings include:

- All three MCES received high overall scores across all EQR-assessed areas related to organizational structure and performance in calendar year 2011.
- CAHPS surveys indicate a high level of member satisfaction with HIP MCEs.
- Among current HIP members surveyed by Mathematica in 2013, 95 percent reported that they were satisfied with their health coverage.

A. OVERALL HEALTH PLAN PERFORMANCE-EXTERNAL QUALITY REVIEW

Calendar Year 2011

In 2012, Burns & Associates, Inc. conducted an external quality review (EQR) of Anthem, MDwise, and MHS for calendar year 2011. At the time of this report, the 2011 EQR represented the most recent available report.

In January 2011, the MCEs entered into a new contract period with the State. As such, the 2011 EQR included a comprehensive organizational assessment of the three MCEs to assess their compliance with federal requirements for Medicaid MCEs. Areas assessed included (1) member services and enrollee rights, (2) grievances and appeals, (3) covered benefits and coordination of

care of physical and behavioral health, (4) provider selection, contracting, and access, (5) utilization management, (6) quality management, (7) information systems, (8) subcontracted relationships and delegations, (9) corporate governance, and (10) billing and POWER account tracking. In addition, Burns & Associates and the State selected three other focused activities for the 2011 EQR, which included (1) validation of performance measures collected in the HHW and HIP reporting manuals, (2) review of inpatient psychiatric stays, and (3) review of the Right Choices Program, a program that aims to reduce inappropriate outpatient hospital and pharmacy use and improve care coordination.

Organizational Assessment and Structure Performance. In total, 259 review items drawn from language in the MCEs' contract with the State were scored. For each item, an MCE could receive 2 points if it met at least 90 percent of the criteria evaluated, 1 point if it met at least 50 percent of the criteria, and 0 points if it did not meet at least 50 percent of the criteria. Of these review items, 108 were directly related to CFR requirements. These were given a weight of "3" in the scoring methodology, while other items related only to contractual requirements were assigned a weight of "1."

All three MCEs received very high overall scores across all assessed areas related to organizational structure and performance, with Anthem receiving a score of 97.2 percent, MDwise scoring 98.4 percent, and MHS scoring 98.4 percent.

Table 6.6.1. Summary of Scores Related to MCE Organizational Assessment and Structure Performance

Review Topic Area	Maximum Score	Anthem Score	MDwise Score	MHS Score
Member Services and Enrollee Rights	248	237	246	245
Grievances and Appeals	120	120	120	120
Covered Benefits and Coordination of Care (other than Behavioral Health)	62	54	55	53
Covered Benefits and Coordination of Care (Behavioral Health)	20	19	18	18
Provider selection, contracting, and access	124	123	124	124
Utilization Management	130	128	129	129
Quality management	48	46	48	48
Information systems	48	48	48	48
Subcontracted relationships and delegations	32	32	31	32
Corporate Governance	56	55	56	56
Billing and POWER Account Tracking	62	61	60	62
Total	**950**	**923**	**935**	**935**
		97.2%	**98.4%**	**98.4%**

Source: Burns & Associates Calendar Year 2011 EQR

Performance Measures. In previous EQRs, Burns & Associates identified three ongoing issues with the reporting of performance measures. On some occasions, the MCEs have interpreted the reporting instructions differently, thereby causing differences in results across MCEs that are related to differences in the methodology used to calculate the measures rather than true

differences in results. In other cases, errors were observed in measure reporting. For example, measures that must be reported on a quarterly basis were not always aligned with year-to-date or four-quarter rolling average results. As a result, THE STATE had three meetings with the MCEs during 2012 to address these issues. After these meetings, Burns & Associates redesigned the HHW and HIP reporting manuals, and these redesigned manuals became effective January 1, 2013.

Review of Inpatient Psychiatric Stays. Beginning January 1, 2011, the State required all MCEs to enroll any HHW or HIP member with an inpatient psychiatric hospitalization into case management for a minimum of 180 days after discharge. In CY 2011, Burns & Associates conducted a review of the rate of readmissions for an inpatient psychiatric stay to assess the outcome of this requirement. This review found that case management had not improved the readmissions rate among this population to any significant degree, and Burns & Associates encouraged the MCEs to work with the State to conduct further research to better understand this population.

Review of the Right Choices Program. The Right Choices Program is intended to reduce inappropriate outpatient hospital and pharmacy use, reduce medical expenditures related to inappropriate use of services, improve an individual's health status through care coordination and utilization control, and increase provider participation in and satisfaction with the Right Choices Program. The calendar year 2011 review of the program resulted in a number of recommendations to the MCEs and the State, which are currently under consideration.

Calendar Year 2012

In early 2013, the State and Burns and Associates (B&A) identified two focus studies that would be completed for the 2012 External Quality Review, in addition to validation (auditing) of performance measures and performance improvement projects for the MCE's. Both focus studies included the HIP population and providers. The two focus studies covered: (1) access to primary care and (2) mental health care utilization and care coordination.

Access to Care. In consultation with the State, B&A constructed a focus study on access to care which included both a quantitative and qualitative component. This analysis expanded the population studied beyond the limits as defined by the HEDIS® measures for access to primary care but limited the study to primary care office visits conducted in a physician office, at a federally qualified health clinic (FQHC), or at a rural health clinic (RHC). Analyses using these parameters were also examined by age, race/ethnicity and region of the state.

The qualitative component to this focus study included interviews with the MCE Provider Services staff in June to learn more about their approach to conducting outreach. B&A then conducted 59 interviews with provider entities contracted with the MCEs over a ten week period from July to September. The interviews included representation of all provider specialties in each region of the state. In total, interviews were conducted at 29 primary medical provider

(PMP) offices, 10 FQHC (Federally Qualified Health Centers), 10 RHCs (Rural Health Centers), and 10 community mental health centers (CMHCs).

The study revealed that MHS provided the greatest access to primary care among the three MCEs. Interestingly, according to the study, access to primary care for African-American members in HIP was higher than other race/ethnicities. There were fewer differences in the rate of access to primary care for adults across the regions than was found for children. Further, the access rates were usually similar across the MCEs within a region. The access rate among HIP adults was higher for every MCE in every region than the corresponding age/region cohort in HHW. This is probably due to the higher provider reimbursement rates provided in HIP.

Provider feedback pertaining to the HHW and HIP programs in general and with MCEs in particular ranged from satisfaction to frustration. B&A analyzed the key factors related to provider satisfaction which included the quality of the MCEs' provider field staff, the quality of assistance and training the office staff received from the MCEs and the ease in getting paid by the MCE. The key factor related to frustration from providers related to consistency across MCEs and programs (i.e., prior authorization submission and adjudication, a single Medicaid manual rather than one for fee-for-service (FFS) Medicaid and separate manuals for each MCE, consistent and accurate claims processing, and consistent responses from customer service representatives). B&A has identified 15 specific recommendations to the State covering many of the topics brought up by providers in the meeting on ways to improve the providers' experience with the program through MCE contract requirements. B&A has also developed 13 recommendations for all of the MCEs as well as some recommendations specific to each MCE.

Mental Health Care Utilization and Coordination. B&A developed a focus study for the 2012 EQR which is a continuation of the work conducted for the 2011 EQR. In this year's EQR, a review of mental health utilization was conducted more broadly for all members of HHW and HIP. Additionally, B&A reviewed the first submissions of the new complex and moderate case management reports for mental health conditions covering 1st Quarter 2013 that were implemented January 1, 2013.

Of all HIP members enrolled in CY 2012, 28.9 percent had a mental health diagnosis reported on an encounter[18]. A greater proportion of white HIP members were diagnosed with a mental health disorder than other races and ethnicities: 31.3 percent of Caucasian members were diagnosed with mental health diagnosis on an encounter compared to 20.2 percent of African-American and 16.6 percent of Hispanics. Among the HIP population, three diagnoses comprised half of all

[18] Milliman's analysis of 2012 claims (MRx algorithim) shows that 23.8 percent of HIP members who had been enrolled in the program for six months or more had a psychiatric diagnosis reported on an encounter record, while B&A's analysis showed 28.9 percent of HIP members enrolled in 2012 had a mental health diagnosis on an encounter. The slight discrepancy in the rate of psychiatric diagnosis on encounters can be attributed to the composition of the claims analysis population. Milliman only considered individuals who had been enrolled for six months or more in 2012 in their analysis, while B&A considered all individuals enrolled in 2012.

mental health diagnoses—tobacco use disorder (19.6% of total), attention deficit disorder (15.5% of total), and major depressive or bipolar disorder (14.9) of total). Outpatient mental health clinics and CMHCs play an important role in the delivery of these services since more than 80 percent of all services were billed by these two provider types. Community mental health providers delivered less than 10 percent of the services (except in Anthem HIP). It is interesting to note that in MDwise HIP, primary care providers rendered a larger proportion of mental health services than the other MCEs.

A sample of cases was reviewed by the EQR Clinical Review Team of two MDs and three RNs, focusing on the care plans developed for the members—whether they contained measurable goals, if they incorporated patient diagnoses, and if the care plan was sent to either PMPs or mental health providers. In addition to the care plan reviews onsite at each MCE in August, the doctors on the clinical team interviewed MCE staff responsible for implementing the MCE's behavioral health program on items required in the contract, the staffing of the behavioral health team, and policies and procedures around case management.

Overall, B & A noted that care plan goals often did not include measures, were not specific to a particular need, and did not address the main physical or mental health diagnosis of the member. Seldom did they address things such as substance abuse, medication compliance, steps to prevent future hospitalizations, ways to ensure and coordinate follow-up with PMP and/or mental health provider appointments, or ways to build toward a healthier lifestyle. The care plan is more focused on helping with appointments, assigning PMPs, etc. While these are important tasks, the function of the care plan should be coordination, medication compliance, and steps to take towards a healthier lifestyle. At all three MCEs, there was little documentation of coordination and integration of information between the PMPs and the mental health providers. The EQR team made recommendations to the State to work with the MCE's to improve the required mental health care plans and case management.

B. SELF-REPORTED SATISFACTION FROM HEALTH PLAN CAHPS DATA

1. MCE Ratings and Benchmarks

CAHPS data indicate a high level of member satisfaction with MCEs (Table 6.6.2). In 2012, all three MCEs received ratings of health care, personal doctor, ability to get needed care, ability to quickly get care, doctor communication, and health education that were higher than the benchmarks selected by the MCEs.

Table 6.6.2 CAHPS Ratings and Benchmarks

CAHPS Rating	Anthem		MDwise		MHS[a]	Benchmark Rates[b]		
						Anthem		MDwise and MHS
	2012 Plan Average	2011 Plan Average	2012 Plan Average	2011 Plan Average	2012 Plan Average	2012 DSS	2012 WP	
Rating of Plan Overall	**82.2***	79.2	**76.0**	75.5	**72.8**	*72.9*	*73.4*	*73.6*
Rating of Health Care	**77.2***	74.7	**70.6**	73.3	**72.7**	*69.1*	*70.6*	*69.3*
Rating of Personal Doctor	**81.0***	78.6	**76.3**	78.8	**79.9**	*76.9*	*77.3*	*76.4*
Rating of Specialist	**77.9**	73.6	**79.8**	75.0	**73.5**	*76.6*	*74.5*	*76.9*
Customer Service	**84.2**	89.3	**82.3**	79.4	**80.2**	*80.0*	*82.8*	*80.5*
Getting Needed Care	**85.1***	85.8	**83.4***	80.6	**79.5**	*75.2*	*77.9*	*77.1*
Getting Care Quickly	**86.6***	86.5	**83.0**	83.6	**83.7**	*79.3*	*81.3*	*81.0*
Doctor Communication	**91.6***	92.6	**88.4**	90.5	**90.0**	*87.7*	*89.1*	*87.7*
Shared Decision Making	**58.2**	65.2	**65.8***	63.2	**66.3**	*59.0*	*59.5*	*59.6*
Health Education	**63.3***	61.4	**60.5**	61.7	**64.5***	*58.3*	*57.2*	*58.9*
Coordination of Care	**77.0**	79.8	**77.2**	77.7	**75.6**	*76.0*	*77.0*	*76.6*

Source: Anthem data are from "2012 CAHPS 4.0H Member Survey prepared for Healthy Indiana Plan" 2012; DSS Research , MDwise data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: MDwise Healthy Indiana Plan" 2012; The Myers Group, and MHS data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: Managed Health Services Indiana, Inc" 2012; The Myers Group

[a]2011 CAHPS data were unavailable for MHS.

[b] Anthem benchmark rates are 2012 WP (WellPoint) averages and 2012 DSS averages (from the 2012 DSS Adult Medical Book of Business averages. The DSS Book of Business is made up of 37 adult Medicaid plans with a total of 15,559 Respondents). MDwise and MHS benchmark rate comes from 2011 Medicaid Adult Public Report.

* Indicates significant difference when compared to corresponding benchmark rates.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; DSS = 2012 DSS Adult Medical Book of Business averages; WP = WellPoint average.

2. Characteristics of CAHPS Respondents

The MCE's were able to obtain samples of respondents that were fairly representative of the overall HIP membership, though survey response rates were approximately 50 percent (Table 6.6.3). Respondents to the CAHPS surveys were more likely to be white than the overall HIP population, and less likely to be black (with the exception of MDwise survey respondents), although assessing the racial mix is challenging because the administrative data do not allow for

multiracial members, but the CAHPS does. Women appeared to be over represented among the survey respondents, particularly among respondents to the MHS CAHPS.

Table 6.6.3 Demographic Characteristics of CAHPS Respondents, by Health Plan

Demographic Characteristics	HIP Members	Anthem Survey Respondents	MDwise Survey Respondents	MHS Survey Respondents
Number	56,245	620	722	421
Response Rate	n/a	47%	56%	47%
Race/Ethnicity				
White	82.0%	86.8%	84.1%	90.9%
Black	10.5%	8.3%	12.3%	6.4%
Hispanic	3.4%	2.3%	4.6%	2.5%
Asian	2.1%	3.9%	1.5%	3.0%
Native American / Alaskan Native	0.1%	1.8%	2.4%	1.7%
Other	1.9%	3.2%	4.5%	2.8%
Gender				
Female	67.6%	69.8%	72.2%	77.8%
Male	32.4%	30.2%	27.8%	22.2%

Source: Anthem data are from "2012 CAHPS 4.0H Member Survey prepared for Healthy Indiana Plan" 2012; DSS Research , MDwise data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: MDwise Healthy Indiana Plan" 2012; The Myers Group, and MHS data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: Managed Health Services Indiana, Inc" 2012; The Myers Group. Data on HIP members are from OMPP.

Note: Race and ethnicity were separate questions in CAHPS surveys, and respondents were able to choose more than one race. Therefore, responses will not equal100 percent. HIP Member data produced by OMPP.

C. SELF-REPORTED SATISFACTION FROM MATHEMATICA'S 2012 SURVEY OF HIP MEMBERS

Mathematica's 2013 survey of current HIP members included questions about satisfaction with HIP. Overall, 76 percent of members reported that they were very satisfied with HIP, while an additional 19 percent said they were somewhat satisfied (Table 6.6.4). Further, 98 percent reported that they would choose to re-enroll in HIP if they left but then became eligible again. Of the small number of individuals who said they were somewhat or very dissatisfied, reasons included lack of coverage of certain benefits (such as dental, vision, or certain procedures), dissatisfaction with choice of doctors, and dissatisfaction with a payment or administrative issue (data not shown). However, the group of individuals asked about their reason for dissatisfaction was too small to provide reliable data.

Table 6.6.4 Satisfaction with HIP

Level of Satisfaction	Total	< 100% FPL	> 100% FPL
Total number	16,830	11,477	5,353
Overall level of satisfaction with HIP			
Very satisfied	76.2%	75.7%	77.1%

Level of Satisfaction	Total	< 100% FPL	> 100% FPL
Somewhat satisfied	18.5%	18.9%	17.7%
Neither satisfied nor dissatisfied	2.1%[b]	2.0%	2.2%
Somewhat dissatisfied	3.0%[b]	3.3%	2.3%
Very dissatisfied	0.2%[b]	0.2%	0.4%
Don't know	0.0%[b]	0.0%	0.0%
Would try to re-enroll in HIP if they left but became eligible again:	16,830	11,477	5,353
Yes	98.2%	98.3%	98.2%
No	0.5%[b]	0.4%[b]	0.7%[b]
Don't know	1.2%[b]	1.2%[b]	1.1%[b]

Source: Mathematica analysis of 2013 survey of HIP members.
[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

D. HEALTH PLAN INQUIRIES

The State maintains a consumer issue management system known as the "Internet Quorum" or "IQ," which permits the State to monitor and manage formal and informal inquiries. In each year, the total number of inquiries has been lower than in the previous years (see Table 5.2 in the Consumer Issues section).Overall, the number of inquiries has fallen by 79 percent between 2008 and 2012.

As in previous years, most inquiries in 2012 were questions of a general nature about HIP (See Table 5.3 in the Consumer Issues section). Eighteen percent of inquiries were about buying into HIP, six percent related to the waiting list, and the remaining were questions regarding specific HIP plans, including the ESP. These percentages are similar to those seen in 2011 (data not shown).

6.7 GOAL VII – ASSURE STATE FISCAL RESPONSIBILITY AND EFFICIENT MANAGEMENT OF THE PROGRAM

The enabling state legislation requires that HIP be a fiscally sound program. While an increase in hospital reimbursement rates effective July 1, 2011 meant that the program did not maintain budget neutrality within DY5, the waiver margin is measured cumulatively, over the course of the five years, the program remained budget-neutral. In 2012, no new cost-saving measures were implemented, and DSH funding allocations remained consistent with previous years.

A. FEDERAL FINANCING ISSUES AND BUDGET NEUTRALITY.

In 2011, the Indiana General Assembly enacted Public Law 229-2011, Section 281, which established a hospital assessment fee program. Under this program, the State collects an assessment fee from certain hospitals, and uses part of the resulting funds to increase hospital reimbursement rates. These new reimbursement rates cannot exceed the Medicare upper payment limits in the aggregate. In May 2012, CMS approved the State Plan Amendment and waivers needed to implement these changes with an effective date of July 1, 2011. All changes are retroactive to this date and will continue until June 30, 2013 (legislation has now extended the fee through June 30, 2017).

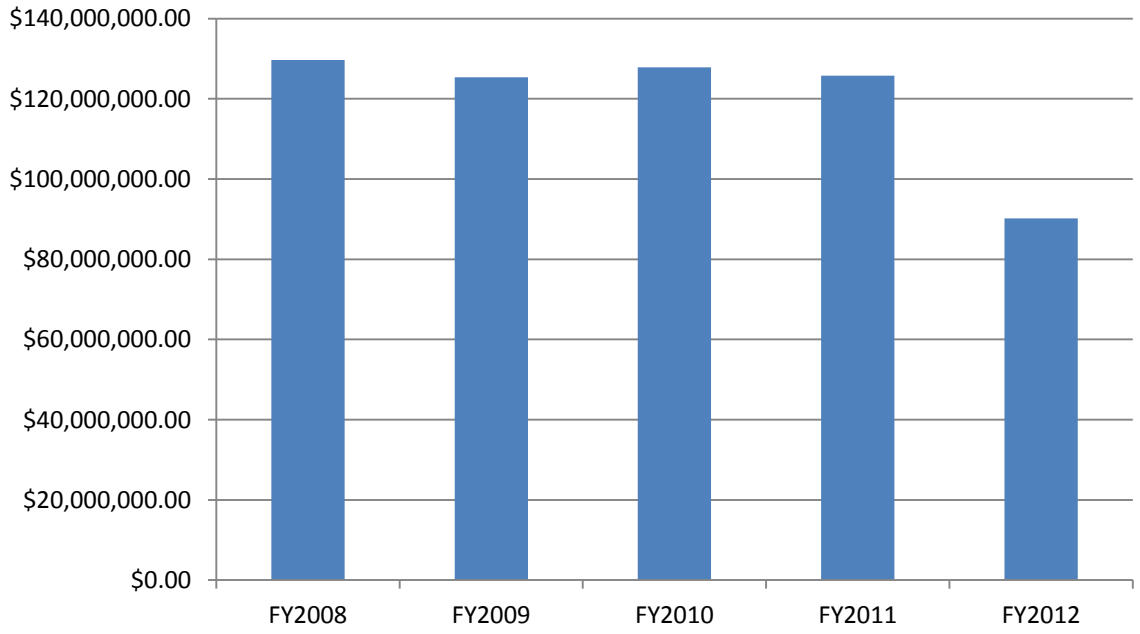
According to estimates by the HIP actuary, Milliman Inc., the state maintained waivers margin well above the total CMS-approved limit from DY1 through DY4. These margins were based on PMPM costs for HHW caretakers, children, and pregnant women, which grew at a slower rate than the projected Medicaid spending established in the Special Terms and Conditions of the HIP waiver. In DY5, however, the waiver margin was negative $73 million due to the increased hospital reimbursement rates described above. These increased rates have led to higher PMPM expenditures for HHW caretakers, children, and pregnant women. PMPM expenditures for HIP caretakers and non-caretakers in DY5 aligned closely with DY4 expenditures for these groups. However, the waiver margin is cumulative, and was maintained across the five years of the demonstration.

B. STATE FINANCING ISSUES

1. Cigarette Tax Revenues

By design, cigarette tax revenues are the dominant financing mechanism for HIP. To date, HIP has collected nearly $599 million in revenues from the cigarette tax implemented in 2007 (Figure 6.6). Cigarette taxes have fluctuated, but have hovered between $120 and $130 million each year.[19] HIP is required to channel $11 million into an immunization fund each year. These payments were not made in FY2010 and FY2011, resulting in a lump sum of $31 million deposited into the fund in FY2012 and a lower level of tax revenues dedicated to HIP during this fiscal year.

Figure 6.6.1 Indiana Revenues from State Cigarette Taxes Allocated to HIP



Source: Mathematica calculations based on data provided by Milliman, May 2013.

2. DSH funds

In 2012, the State continued to reallocate about $50 million in existing Disproportionate Share Hospital (DSH) dollars to HIP. This is the same amount that had been reallocated in each previous year of the waiver However, the 2012 waiver extension included a request to restore DSH funding, since the State had achieved its waiver margins.

3. Power Account Contributions

The monthly contributions that HIP members make to their POWER accounts are the third mechanism for funding HIP. POWER accounts are set at $1,100 per year. The monthly contributions are based on income and a sliding scale. Members may pay as much as 5 percent of their income. Mathematica estimates that the maximum POWER account contributions for 2008 and 2009 were on average less than $20 million per year, but for 2010 were closer to $30 million. In 2011 and 2012, total estimated POWER account contributions were again less than $20 million.

SECTION 7: CONCLUSIONS

The HIP program has proven to be a promising model for expanding access to healthcare for low-income populations who are otherwise not eligible for Medicaid coverage. As demonstrated throughout this report, a consumer-driven health model promotes more conscious healthcare utilization and engagement in decision-making. HIP members overwhelmingly report that they value their health coverage, would be willing to make higher POWER account contributions to remain enrolled, and prefer paying "up front" (funding the POWER account) to making copayments each time they seek medical care. Eighty-five percent of members feel that their required contributions are either the right amount or below the right amount, and only a small proportion (14 percent) of former HIP members reported that cost-sharing had been their reason for leaving the program. Overall initial POWER account contribution rates have increased steadily over the course of the demonstration, indicating that contribution amounts are affordable and that members value having coverage. HIP members continue to report high overall satisfaction with the program, and demand for HIP coverage continues to grow, as evidenced by the rate at which the non-caretaker waitlist has grown until it was closed in December of 2012.

Overall uninsurance rates for the HIP-eligible population have increased slightly over the years of the demonstration, likely due to external factors such as the national recession and higher rates of unemployment. However, the uninsurance rates for those Hoosiers under 50 percent of the FPL have actually *decreased* approximately four percentage points from 2007 (before the program was first implemented) until 2012. HIP has very plausibly been a primary driver of that outcome. Additionally, if HIP had not been available, the state uninsurance rate would likely have increased more during the demonstration period than it actually did due to general economic conditions.

HIP has accomplished all of these goals while maintaining fiscal soundness. Over the course of the five years of the demonstration, HIP has cost approximately $1 billion. The overall five-year waiver margin is $1.1 billion. With the exception of the cigarette tax revenue used to fund the program, HIP has no other impact on Hoosier taxpayers.

Over the life of the program, challenges with MCE provider networks and process issues in providing care have been addressed. Provider networks have improved significantly for both primary and specialty care in the five years of the demonstration. There are still areas where improvements can be made, including increased member awareness of how the POWER account works and understanding of the connection between receipt of preventive care, account rollovers, and reduced contributions. The State continues to work with the MCE's to meet quality metrics and implement effective chronic disease management programs.

Overall, HIP has experienced marked success in making healthcare accessible to a vulnerable, low-income population which otherwise would have had no avenue to public coverage in the past five years. The State anticipates continued accomplishments and improvements over the extension years. Additionally, the State continues to seek guidance on the future of the HIP program from CMS in the context of the Affordable Care Act of 2010.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

January 15, 2013

Michael Gargano
Secretary
Indiana Family and Social Services Administration
402 W. Washington St.
P.O. Box 7083
Indianapolis, IN 46207-7083

Dear Mr. Gargano:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Indiana's December 27, 2011, request to extend its section 1115 Healthy Indiana Plan (HIP) demonstration (project number 11-W-00237/5). This extension is effective through December 31, 2013. At the state's request, several changes to the demonstration have been incorporated into the Special Terms and Conditions (STCs), waivers and expenditure authorities for the extension approval, which are summarized as follows:

- Addition of authority for not-for-profit organizations to contribute up to 75 percent of a beneficiary's POWER account;

- Removal of the additional savings projects that improved Medicaid operations, such as more effective cost recovery efforts, from the STCs as these projects were completed during the first five years of the demonstration; and

- Removal of the Disproportionate Share Hospital (DSH) funding from the state's budget neutrality agreement.

We have also added a provision in the STCs that the state reconcile expenditures through the CMS MBES/CBES reporting system and demonstrate budget neutrality for the prior approval period of demonstration year (DY) 1 through DY 5 no later than March 31, 2013. State amendments to the demonstration are contingent on the state completing the reconciliation process.

As indicated in our July 31, 2012, letter, we share the state's goal of maintaining coverage for the approximately 42,000 parents and childless adults enrolled in the HIP program, and are committed to continuing our discussions with the state regarding options for 2014. We are happy to meet with the state to discuss potential approaches.

As this approval extends your demonstration through December 31, 2013, we also wanted to clarify the timeframe in which the state may submit a request to extend its demonstration. The STCs have been revised to reflect an extension request submission date of June 30, 2013, in accordance with the applicable regulations at 42 C.F.R. §431.412(c). You are also welcome to submit your extension request at any earlier point.

The CMS approval of the HIP extension is conditioned upon continued compliance with the enclosed set of STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the revised STCs, waivers and expenditure authorities is enclosed.

Your project officer for this demonstration is Ms. Jessica Schubel. She is available to answer any questions concerning your section 1115 demonstration and this extension. Ms. Schubel's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3032
Facsimile: (410) 786-5882
E-mail: Jessica.Schubel@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Schubel and to Ms. Verlon Johnson, Associate Regional Administrator for the Division of Medicaid & Children's Health in the Chicago Regional Office. Ms. Johnson contact information is as follows:

Ms. Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children Health Operations
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

We extend our congratulations to you on this award and we appreciate your cooperation throughout the review process. If you have additional questions, please contact Ms. Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

cc: Verlon Johnson, ARA, Chicago Regional Office
Jennifer Ryan, CMCS
Patricia Cassanova, Medicaid Director, Indiana Family and Social Services Administration

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **No. 11-W-00237/5**

TITLE: **Healthy Indiana Plan (HIP) Medicaid Section 1115 Demonstration**

AWARDEE: **Indiana Family and Social Services Administration (FSSA)**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the State plan mandatory and optional populations. In addition, the provisions of the Social Security Act (the Act) specifically listed as waived in this list are "not applicable" to the demonstration populations made eligible through expenditure authority, as specified in the individual waivers.

The demonstration will operate under these waiver authorities and those provisions specified as "not applicable" beginning January 16, 2013. The waiver authorities and the provisions specified as "not applicable" will continue through December 31, 2013, unless otherwise stated.

The following waivers and references to the Act specified as "not applicable" shall enable Indiana to implement the HIP Medicaid section 1115 Demonstration.

Title XIX Waivers

1. **Statewideness/Uniformity** **Section 1902(a)(1)**

   To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

2. **Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B)**

   To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the Hoosier Healthwise program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in Hoosier Healthwise.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups through mandatory enrollment of eligible individuals in managed care organizations and/or Prepaid Inpatient Health Plans that do not meet the

requirements of section 1932 of the Act. No waiver of freedom of choice is authorized for family planning providers.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00237/5**

TITLE: **Healthy Indiana Plan (HIP) Medicaid Section 1115 Demonstration**

AWARDEE: **Indiana Family and Social Services Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Indiana to implement the Medicaid section 1115 Demonstration (Healthy Indiana Plan).

1. **Demonstration Population 4 (HIP Caretakers).** Expenditures for health care related costs for uninsured adults who are custodial parents and caretaker relatives of children eligible for Medicaid and the Children's Health Insurance Program (CHIP) with family income up to and including 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or Medicare, who do not have access to an employer-sponsored health plan, have been uninsured for 6 months, and whose health care expenditures do not exceed a $1 million lifetime maximum on benefits under the demonstration.

2. **Demonstration Population 5 (HIP Adults).** Expenditures for health care related costs for uninsured adults who are non-custodial parents or childless adults, ages 19 through 64 with family income up to and including 200 percent of the FPL, who are not otherwise eligible for Medicaid or Medicare, who do not have access to an employer-sponsored health plan, have been uninsured for 6 months, and whose health care expenditures do not exceed a $1 million lifetime maximum on benefits under the demonstration.

3. **Expenditures Related to MCO Enrollment and Disenrollment.** Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Indiana managed care plans which serve HIP members will be required to meet all requirements of section 1903(m) of the Act except the following:

   Section 1903(m)(2)(A)(vi) and (xi) insofar as they incorporate Federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) of the Act are inconsistent with the disenrollment rules contained in paragraph 31 of the Demonstration's Special Terms and Conditions, such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 60 days of enrollment in an MCO or before they make their first POWER account

contribution, whichever occurs first. Enrollees may disenroll from an MCO with cause at any time.

4. **Payments for Non-Risk Contractor**
   Payments to the HIP Indiana Comprehensive Health Insurance Association prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the State plan in accordance with the upper limits at 42 CFR 447.362. Payments shall not exceed Medicare reimbursement rates.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Population 4 and Demonstration Population 5 beginning January 16, 2013, through December 31, 2013.

Title XIX Requirements Not Applicable to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults)

1. Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER Account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER Account.

2. Methods of Administration: Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana to not assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

3. Eligibility Section **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER Account.

4. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer benefits to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration, and scope of services offered to individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of $300,000.

5. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

6. Freedom of Choice **Section 1902(a)(23)(A) insofar as it incorporates 42 CFR 438.52(a)**

To the extent necessary to enable Indiana to provide only one choice of plan for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are identified as having certain high-risk conditions. No waiver of freedom of choice is authorized for family planning providers.

7. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER Account.

8. Prepayment Review **Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana to not ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. Premiums **Section 1902(a)(14) insofar as it incorporates section 1916(a)(1)**

To the extent necessary to enable Indiana to charge premiums for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. Dental and Vision Coverage for Certain HIP Caretakers and HIP Adults **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00237/5**

TITLE: **Healthy Indiana Plan**

AWARDEE: **Indiana Family and Social Services Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Indiana's Healthy Indiana Plan (HIP) section 1115(a) Medicaid demonstration (hereinafter referred to as "demonstration"). The parties to this agreement are the Indiana Family and Social Services Administration ("state") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective January 16, 2013, unless otherwise specified. This demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Affected Populations and Populations Made Eligible under the Demonstration
V. Hoosier Healthwise
VI. Healthy Indiana Plan
VII. General Reporting Requirements
VIII. General Financial Requirements
IX. Monitoring Budget Neutrality for the Demonstration
X. Evaluation of the Demonstration
XI. Schedule of State Deliverables during the Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

This section 1115(a) demonstration provides authority for the state to offer two distinct health care coverage benefit packages to specified populations. The Hoosier Healthwise (HHW) Program supplements state plan benefits for Medicaid eligible children and those otherwise eligible adults who are not aged, blind or disabled. The HIP provides health care coverage for uninsured adults not otherwise eligible for Medicaid through a high deductible managed care health plan and an account styled like a health savings account called a Personal Wellness and Responsibility (POWER) Account. Separate from this demonstration, Indiana offers the Indiana Select Program which includes case management services to supplement state plan benefits

offered through Medicaid Select managed care programs for current Medicaid eligible adults who are aged, blind or disabled.

Hoosier Healthwise Program

Indiana began the Hoosier Healthwise program in 1994, when it initially mandated managed care enrollment for all section 1931 children and adults through a waiver granted by the Secretary under the authority of section 1915(b) of the Social Security Act (the Act). By July 1997, the program was implemented statewide using a combination of managed care organizations (MCOs) and a Primary Care Case Management (PCCM) delivery system. Effective December 2005, all Hoosier Healthwise enrollees are served exclusively by MCOs.

Effective January 1, 2008, the authority for the Hoosier Healthwise program was provided solely through this demonstration.

Healthy Indiana Plan (HIP)

The HIP provides a high-deductible health plan and an account styled like a health savings account called a POWER Account to uninsured adults including low-income custodial parents and caretaker relatives of Medicaid and Children's Health Insurance program (CHIP) children and uninsured non-custodial parents and childless adults. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through the high deductible health plans and POWER Accounts. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the health plan will provide coverage for medical services up to an annual maximum amount. Eligible individuals who have certain high-risk conditions will be enrolled in the Enhanced Services Plan (ESP), a separate care delivery mechanism managed by the Indiana Comprehensive Health Insurance Association (ICHIA), the state's high-risk pool.

HIP offers the following coverage:

1) A basic commercial benefits package once annual medical costs exceed $1,100;

2) A Personal Wellness and Responsibility (POWER) Account valued at $1,100 per adult to pay for initial medical costs. The POWER Accounts provide incentives for participants to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER Accounts depending on their income level; and

3) $500 in "first dollar" preventive benefits at no cost to HIP members.

Under this demonstration, Indiana expects to achieve the following to promote the objectives of title XIX:

- Access: Ensure availability of necessary health services for Medicaid enrollees while offering health coverage to thousands of uninsured individuals;
- Prevention: Encourage individuals to stay healthy and seek preventive care;
- Personal Responsibility: Give individuals control of their health care decisions and incentivize positive health behaviors;
- Cost Transparency: Make individuals aware of the cost of health care services; and
- Quality: Encourage provision of quality medical services to all enrollees. Encourage quality, continuity, and appropriate medical care.

The following populations will participate in the Hoosier Healthwise (HHW) component of the demonstration. The three populations derive their eligibility through the Medicaid state plan.

- **HHW Population 1: HHW Caretakers.** HHW Caretakers include parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the state plan and resources less than or equal to $1,000.
- **HHW Population 2: HHW Children.** HHW Children include all children eligible for Medicaid under the Medicaid state plan.
- **HHW Population 3: HHW Pregnant Women.** HHW Pregnant Women include pregnant women eligible under Medicaid up to and including 200 percent of the federal poverty level (FPL).

The following populations will participate in the HIP component of the demonstration:

- **Demonstration Population 4: HIP Caretakers.** HIP Caretakers include uninsured custodial parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the state plan with resources in excess of $1,000 who make POWER account contributions; and, uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family income above the AFDC income limit specified in the state plan through 200 percent of the FPL (no resource limit) who make POWER account contributions.

- **Demonstration Population 5: HIP Adults.** HIP Adults include uninsured non-custodial parents and childless adults (ages 19 through 64) who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200 percent of the FPL (no resource limit) who make POWER account contributions.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived

or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy statement affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as necessary, to comply with such change. The modified budget neutrality agreement would be effective upon implementation of the change.

   b. If mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state shall not be required to submit title XIX state plan amendments (SPAs) for changes demonstration affecting any populations made eligible solely through the demonstration. If a population covered through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Demonstration Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a) An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment.

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX state plan amendment, if necessary; and

d) If applicable, a description of how the evaluations design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration**.

a) States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

b) Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 14 as well as include the following supporting documentation:

i. Historical Narrative Summary of the demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information.

Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical, and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR section 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
   a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out

plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS's approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, state Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration whenever it determines following a hearing, that the state has materially failed to comply with the terms of the project. CMS shall promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX.

CMS shall promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

    In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. section 431.408(b)(2)).

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. section 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment

15. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. AFFECTED POPULATIONS AND POPULATIONS MADE ELIGIBLE UNDER THE DEMONSTRATION

16. **Populations.** This demonstration includes two distinct components. The following is an overview of eligibility for the two components, which are described in more detail in Tables 1 and 2.

a. Under the HHW program, children, pregnant women and caretaker adults who are otherwise eligible under the state plan (with the exception of such adults who are eligible as aged, blind or disabled)receive state plan benefits and additional HHW benefits through comprehensive managed care organizations as described below.
b. Under the HIP program, uninsured adults with and without children who have specified income and assets and are not otherwise eligible under the state plan or Medicare receive benefits through a high-deductible managed care health plan and, as a condition of eligibility, contribute to a POWER Account.

The mandatory and optional Medicaid state plan populations described below in Table 1 derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived.

Groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration as described below in Table 2 are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as specifically waived or identified as not applicable to the expenditure authorities.

The eligibility criteria for this demonstration are outlined below. These tables are presented for information purposes and do not change the state plan requirements or otherwise establish policy.

Table 1: Hoosier Healthwise Program Populations

Description	FPL Level and/or other qualifying criteria	Demonstration Eligibility Group
State Plan Mandatory and Optional Groups		
Pregnant women	0% FPL through 200% FPL; no resource limit	HHW Pregnant Women
Qualified Pregnant Women	Pregnant women up to the AFDC income limit for the particular family size as indicated in the state plan; resource limit of $1,000	HHW Caretakers
Children under age 1	0% FPL through 200% FPL; no resource limit	HHW Children
Newborns born to & living with a woman who was eligible and received Medicaid on the date of the child's birth	Eligible for 1 year as long as mother is eligible for Medicaid or would be if pregnant and the child remains in the same household as mother.	HHW Children
Children 1 through 5	0% FPL through 133% FPL; no resource limit	HHW Children

Children 6 through 18	0% FPL through 100% FPL; no resource limit	HHW Children
Blind and Disabled children under age 18 receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the state plan FPL; resource limit of $1,000	HHW Children
Custodial parents and caretaker relatives of children eligible for Medicaid	Income up to and including the AFDC income limit for the particular family size as indicated in the state plan; resource limit of $1,000	HHW Caretakers
Blind and Disabled adults 18 years old and older receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the state plan; resource limit of $1,000	HHW Caretakers

Table 2: Healthy Indiana Plan (HIP) Program Populations

Description	FPL Level and/or other qualifying criteria	Demonstration Eligibility Group
Demonstration Eligible Groups		
Custodial parents and caretaker relatives currently excluded from the Medicaid state plan who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income up to the AFDC income limit for the particular family size as indicated in the state Plan with resources in excess of $1,000	HIP Caretakers
Custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income above the AFDC income limit for the particular family size as indicated in the state Plan and up to and including 200% FPL; no resource limit.	HIP Caretakers
Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers,	0% FPL through 200% FPL; no resource limit. At no point in time may the number of non-custodial parents and childless adults exceed	HIP Adults

Description	FPL Level and/or other qualifying criteria	Demonstration Eligibility Group
Demonstration Eligible Groups		
who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	36,500.	

17. **Excluded Individuals.** Notwithstanding the eligibility criteria in paragraph 16, the following persons are excluded from the populations described above.

    Hoosier Healthwise Program
    - Persons eligible for Medicaid exclusively through categories other than those listed above in Table 2.
    - Individuals eligible for Medicare.

    Healthy Indiana Plan
    - Individuals otherwise eligible for Medicare or Medicaid.
    - Individuals who have access to an employer-sponsored health plan.
    - Individuals who are currently enrolled in a health insurance program.

18. **Enrollment Cap for HIP Adults.** At no point in time may the number of noncustodial parents and childless adults enrolled in HIP exceed 36,500.

V. HOOSIER HEALTHWISE

19. **Benefits.** Benefits offered to HHW enrollees include all benefits available under the state plan and additional chronic disease management services. All benefits, with the exception of pharmacy, are delivered through a managed care delivery system. Effective January 1, 2010, pharmaceutical services are provided through a fee-for-service delivery system.

20. **Enrollment.** The state will continue to follow applicable federal law and regulations for determining eligibility for Medicaid and for enrolling those deemed eligible into MCOs, as well as policies and procedures that are described in the Medicaid state plan. The state may require members of the Medicaid eligibility groups described in paragraph 16 to enroll with an MCO as a condition for receiving medical assistance. The state may allow MCOs to assist enrollees in completing their applications for redeterminations; however, the state will be responsible for making the redetermination decision.

21. **Cost Sharing.** Any cost sharing requirements for HHW enrollees are stipulated in the Medicaid state plan.

VI. HEALTHY INDIANA PLAN (HIP)

22. **General Description.** Individuals enrolled in HIP receive the benefits described in STC 30 and 31 through a high-deductible managed care health plan and an account styled like a health savings account called a POWER Account described in STC 35. All enrollees will receive covered services through one of two delivery systems described in STC 26 below. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the HIP MCO or Enhanced Services Plan (described below) will provide coverage for medical services up to an annual maximum amount.

    The state provides benefits under the HIP using one of two delivery systems. For those enrollees who have an identified high-risk condition, benefits are rendered through the Enhanced Services Plan, a prepaid inpatient health plan (PIHP), operated by ICHIA, the same entity that manages the state's high risk pool. All other enrollees receive coverage through MCOs under contract to the state. The MCOs and ESP are subject to the federal laws and regulations as specified in 42 CFR Part 438.

    In all cases, the enrollee is responsible for making contributions to a POWER Account.

<u>Eligibility Determination, Enrollment, and Disenrollment</u>

23. **Enrollment.** Individuals may apply for HIP in one of two ways. Applicants may apply at Designated Enrollment Centers or directly at the Division of Family Resources (DFR) offices.

    a. **Application through Designated Enrollment Centers (DEC).** Individuals may complete an application through designated enrollment centers (such as hospitals, schools, community organizations, health clinics, etc.). The state will ensure that the DECs, as outstationed eligibility centers, comply with the regulations set forth at 42 CFR 435.904. The applicant may make an MCO selection at this time. As part of the application, a high-risk health questionnaire will also be required.

        The DECs will forward complete applications, including all supporting documentation, to DFR within 35 days of the application's signature date, either online or via U.S. mail. DFR will make a final eligibility determination within 45 days of the signed application date. This 45-day period is inclusive of the 35 days the DEC has to forward the completed application to DFR.

    b. **Application through the Division of Family Resources (DFR).** The DFR will explain the HIP program and take an enrollee's application for the program. Individuals will also be able to apply for HIP online, over the phone, and by mail. The applicant may make an

MCO selection at the time they apply. As part of the application, a high-risk health questionnaire will also be required.

The applicant's application form will be checked for completeness through an automated process. If the application is not complete, DFR will contact the applicant to obtain the missing information. DFR will make a final eligibility determination within 45 days of the signed application date.

24. **MCO Information and Selection.** The state will contract with an enrollment broker to assist interested applicants with their MCO selection so they can make an informed decision. The enrollment broker will provide the applicant with appropriate counseling on the full spectrum of available MCO choices and will address any questions the applicant may have. Once an MCO has been selected, the enrollee is required to remain in that MCO for 12 months (coverage term), with limited exceptions specified in paragraph 27.

    Individual family members may select different MCOs. If no family member receives coverage through ESP and no eligible family member has selected a plan, all eligible family members will be auto-assigned to the same MCO. If one of the family members receives coverage through ESP as described in paragraph 25, and no family member has selected a plan, all non-ESP family members will be auto-assigned to the same MCO.

25. **The Enhanced Services Plan for Individuals with High Risk Conditions.**

    a. If the high-risk health questionnaire completed at the time of application indicates that the applicant has one of the ESP-eligible conditions, the applicant will be enrolled by the state in the ESP. The state will determine which conditions are eligible for the ESP program on an annual basis and will indentify these conditions in the MCO contracts. Some examples of conditions that are eligible for the ESP program include cancer, past recipient of organ and/or tissue transplants or awaiting an organ and/or tissue transplant, HIV/AIDS, aplastic anemia, or hemophilia. ESP is a PIHP that is managed by ICHIA, the organization that also manages the state's high risk pool. Persons enrolled in ESP will have access to the provider network maintained by ICHIA, and will be free to receive care from any ICHIA affiliated provider. The ESP specializes in managing populations with high-risk medical conditions. ESP members will receive disease and case-management services that will assist them in managing their health conditions.

    b. Demonstration eligibles assigned to ESP will be required to make monthly POWER Account contributions, with amounts determined on the same basis as for HIP MCO enrollees, following paragraphs 36 and 37. Indiana may elect either option (i) or (ii) below with respect to implementation of POWER Accounts for persons assigned to ESP. The state must include a report on which option it is currently using, and any plans to change the option, in each Quarterly Progress Report (as required under paragraph 53).

        i. Indiana may elect to make state contributions to ESP enrollees' POWER Accounts, as described in paragraph 37. The state will require ESP to manage their enrollees' POWER Accounts, in conformity with paragraphs 38 through

46. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 30, once their annual deductible has been reached, as well as disease management services provided by ESP. The state will reimburse ESP for the cost of all services provided to an enrollee in excess of those defrayed through the enrollee's POWER Account.

Indiana may elect not to make state POWER Account contributions to ESP enrollees' POWER Accounts. In this case, ESP must collect the required monthly POWER Account contributions and will use these monies to defray the cost of services provided to ESP enrollees within the coverage term. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 34, as well as disease management services provided by ESP. The state will reimburse ESP for the cost of services provided to an enrollee beyond those defrayed by the enrollee's POWER Account contributions. If, during the course of a coverage term, an individual's medical claims do not exceed $1,100 for the year, the enrollee's required contribution for the new year will be based on the POWER Account carry-forward procedures, as described in paragraph 36(c), and calculated as if the state had made a full POWER Account contribution as stipulated in paragraph 37(a).

c. Demonstration eligibles assigned to ESP will not be considered to be enrolled in ICHIA, the state's high risk pool; ESP will provide only administrative services and access to the ICHIA provider network. ESP will also provide disease management services.

d. If the high-risk condition was not disclosed on the high-risk health questionnaire or is not identified on the application, but is on the list ESP-eligible conditions, the MCO may refer an individual to the ESP Plan. The requirements governing the MCO's referral are outlined in the MCO contracts. In general, the MCO's referral must be supported by the documentation required by the state's referral criteria such as the appropriate physical examination, initial claims data, and/or physician questionnaire. In general, if the state does not receive the MCO's notification and/or request to transfer the enrollee to ESP within 180 days (or the time period denoted in the MCO contract), the enrollee will remain in the MCO for the rest of the coverage term. At the end of the coverage term, the MCO will have another opportunity to use prior claims data, a physician exam, or a physician questionnaire as determined by the state's referral criteria to transfer the enrollee to ESP. The MCOs will be subject to an audit of their transfers of HIP members to the ESP. The specifics of the audits and the penalties associated with the audits are outlined in the MCO contracts.

e. At the time of redetermination, the state may transfer an enrollee from ESP to an MCO if the state or its designee determines that the enrollee does not have an ESP-eligible condition. The requirements governing how an ESP member could be transferred to an MCO are outlined in the MCO and ESP contracts. In general, if a member is not found to have an ESP-eligible condition, the member will be sent a notice informing the member that he or she will be transferring from the ESP to their MCO choice once the redetermination is completed. The notice will inform the member that the member may make a new plan choice.

The state will develop a process through which a HIP member may appeal the state's decision to move the member out of an MCO to ESP or out of ESP to an MCO. The state shall include a description of this process in the first Annual Report required in paragraph 53.

26. **HIP Managed Care Organizations**. Any HIP participant who is not enrolled in the ESP shall be enrolled to receive service through an MCO. The HIP participant will be given an opportunity to select an MCO at the time of application. A HIP participant who does not make an MCO selection at the time of application may be auto-assigned to a HIP MCO by the state. Auto-assignment may occur after the date in which the state determined their eligibility, or 14 days after the application's signature date, whichever is later.

    Auto-assignment will be done on a rotating basis to assure that applicants are assigned evenly among MCOs. The state may consider assignment to the lowest cost MCO, or to the MCOs that demonstrate strong health outcomes and quality health care services. Enrollees will be advised promptly of the auto-assignment and their right to change MCOs before the first POWER Account contribution is made.

27. **Enrollee's Right to Change MCOs.**

    a. At the beginning of their first coverage year, an enrollee may change HIP MCOs without cause within 60 days after initially choosing or being auto-assigned to a HIP MCO, or the date their HIP MCO received their first POWER Account contribution, whichever comes first.

       The state shall notify HIP members 90 days before the end of their coverage term that they must apply for continued coverage. The state shall also notify HIP members that they may change plans without cause at the time they submit their application for a second or subsequent coverage term. Members may seek assistance from the enrollment broker in choosing an MCO.

    b. "Cause" is defined as "receiving poor quality care coverage," which includes, but is not limited to, the following:
       i. Failure of the Insurer to provide covered services;
       ii. Failure of the Insurer to comply with established standards of medical care administration;
       iii. Significant language or cultural barriers.
       iv. Corrective Action levied against the Insurer by the Family and Social Services Administration (FSSA); or
       v. Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

    c. The enrollee must submit his or her request for change to the enrollment broker either orally or in writing. The enrollment broker will assure that the enrollee has sought redress through the MCO's grievance system before referring the request to the state

for making a determination regarding the change request. The enrollee shall still have access to the state's normal grievance and appeals process required under the managed care regulations.

d. If the state fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the request for change will be considered approved and the enrollee will be transferred into the new MCO.

e. If an enrollee is transferred from the MCO, the MCO must disable the enrollee's POWER Account card immediately, and return the remaining balance of the individual's POWER Account balance to the state within 30 days of the last date of participation with the MCO. The state will then provide the entire POWER Account balance to the new MCO with the information needed to properly track the individual's contribution.

f. The state will ensure that all transferring individuals receive coverage from their new MCO promptly, without any interruption in coverage.

28. **Redetermination of Eligibility**. Redetermination of eligibility for HIP will occur at least once every 12 months. An enrollee may request a redetermination of eligibility for HIP due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the state must perform such redeterminations upon request. Requests for redetermination based on changes in income will be subject to a once a year qualifying event. A "qualifying event" is defined as a job loss or other event resulting in a change in income. Each redetermination must include a reassessment of the individual's eligibility for Medicaid, and may result in a reduction of the enrollee's required POWER Account contribution. The state may consider allowing more than one "qualifying event" a year on a case-by-case basis, if the HIP member experiences a job loss or other change in income that results in undue hardship. The enrollee's MCO may assist the enrollee in completing the steps necessary to remain eligible for HIP.

29. **Disenrollment from HIP unrelated to POWER Accounts.** The state may disenroll an enrollee from HIP for any of the following reasons:

a. The enrollee is determined ineligible for HIP at redetermination;

b. The enrollee obtains access to employer-sponsored coverage;

c. The enrollee becomes covered under another health insurance policy or FSSA program; or

d. The enrollee becomes pregnant. Upon pregnancy, the enrollee will become eligible for Hoosier Healthwise, and will be enrolled in that program.

e. Should a participant be disenrolled from HIP for any of the reasons listed above, the HIP MCO must return any remaining POWER Account balances to the participant or the state as described in paragraph 44.

Benefits

30. **HIP Covered Benefits.** HIP covers physical, behavioral health and pharmacy services as specified below. All benefits are limited by medical necessity as defined by the state. This list of benefits specifies the minimum set of benefits available to HIP members.

Table 3: Healthy Indiana Plan Benefits

Benefit	Limits
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service
Skilled Nursing Facility	Subject to a 60-day maximum
Outpatient Facility	
Surgery	
Emergency Room	Co-payment for services determined to be non-emergency as specified in Section VI, paragraph 33(b)
Urgent Care	
Physical/Occupational/ Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Pharmacy and Blood	
Cardiovascular	
Professional Services	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient/ ER Visits	
Office Visits/ Consults	
Preventive Services	At least $500 annual first dollar coverage
Physical/Occupational/Speech Therapy	25-visit annual maximum for each therapy
Cardiovascular	
Radiology/Pathology	
Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness
Ancillary Services	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available.
Home Health (including hospice)/ Home IV Therapy	Excludes custodial care. Includes case management.

Ambulance	Emergency ambulance transportation only, subject to the prudent layperson's standard.
Durable Medical Equipment/ Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).
Lead Screening Services	Ages 19 and 20 only
Hearing Aides	Ages 19 and 20 only
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services	Subject to the HIP benefit coverage limits
Disease Management Services	

31. **Preventive Benefits.**

a. Enrollees will have an annual budget of at least $500 for "first dollar coverage" to pay for preventive services. Enrollees may not be required to pay any cost sharing for the first $500 of preventive services in any coverage year. The first $500 in preventive care service will not count against the $1,100 annual deductible and will not be accessed using the enrollee's POWER Account card. Preventive services in excess of the "first dollar coverage," are covered, but are subject to the deductible.

b. For coverage terms beginning the first year of the demonstration, each enrollee is required to receive an annual physical by the end of their 12-month eligibility period. For subsequent years of the demonstration, each enrollee will be required to access the appropriate preventive services (defined as care that is provided to an individual to prevent disease, diagnose disease, or promote good health) for their specific age and gender as described in paragraph 31(c) below. These requirements are for purposes of the carry-forward of POWER Account funds described in paragraph 42(c).

c. As part of the first Quarterly Progress Report (as required under paragraph 52), the state will submit a list of the services (including services codes) that are considered to be preventive services that can be provided from the $500 of "first dollar coverage," and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds described in paragraph 23(c). Any changes to these must be reported by the state in a subsequent Quarterly Progress Report. The current preventive services requirements to receive full carry-forward of POWER Account funds must be posted promptly to FSSA's public Web site.

32. **Annual and Lifetime Benefit Limits.** The benefits available under HIP are limited to $300,000 annually and $1 million over a lifetime.

a. If during a coverage term, an enrollee exceeds the annual benefit limit of $300,000, the enrollee will remain enrolled in the MCO or ESP and must continue to make POWER Account contributions; however, the enrollee will not have access to covered services. After redetermination and at the beginning of a new coverage term, the enrollee will have reinstated access to covered services.

b. If an enrollee exceeds the lifetime benefit limit of $1 million, the enrollee will be disenrolled from HIP following the procedures specified in paragraph 45(c). If enrollees exceed $200,000 in benefits in a year or $900,000 in benefits in a lifetime, they must be informed that they may apply for Medicaid, Medicaid for Employees with Disabilities (M.E.D. Works), and/or ICHIA, the state's high risk pool. Notices must be provided to ensure the enrollee has a reasonable time to provide the necessary documentation.

Cost Sharing

33. **Allowable HIP Cost Sharing**

a. HIP enrollees may be subject to cost sharing only as described in (b) below. Neither the required monthly POWER Account contributions discussed in paragraph 35, nor payments made from the POWER Account to defray the cost of services prior to the deductible being reached, are considered cost sharing for this purpose.

b. HIP enrollees may be charged co-payments for non-emergency use of a hospital emergency department, subject to the following conditions.

i. The maximum amounts that can be charged to HIP enrollees are as follows:

Population	Co-Payment Amount
HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the state plan through 100% FPL	$3 per visit
HIP Caretakers Above 100 % through 150% FPL	$6 per visit
HIP Caretakers Above 150 % through 200% FPL	Lower of 20 percent of the cost of the services provided during the visit, or $25
HIP Adults	$25 per visit

ii. The conditions stated in section 1916A(e)(1) of the Act and in the August 15, 2007, State Medicaid Directors Letter (SMDL) #07-010 must be met.

iii. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.

iv. Assuming the individual actually has an available and accessible alternate non-emergency services provider and a determination has been made that the individual does not have an emergency medical condition, the hospital must inform the individual before providing non-emergency services that:

- The hospital may require payment of the above-named cost sharing before the service can be provided.
- The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible.
- An alternate provider can provide the services without the imposition of the state-specified higher cost sharing for the inappropriate use of the ER.
- The hospital provides a referral to coordinate scheduling of this treatment.

v. The co-payment for HIP Caretakers must be refunded if the person is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Act, or if the person is admitted to the hospital on the same day as the visit. The co-payment for HIP Adults need not be refunded.

c. For families that include HIP Caretakers, the total aggregate amount of POWER Account contributions, Medicaid and HIP cost sharing, and CHIP premiums and cost sharing may not exceed 5 percent of the family income of the family involved. Family income will be determined under the methodology applicable to the group under the state Medicaid plan. The state must develop a process for ensuring that families do not exceed the 5 percent cost sharing limit, and must include a description of this process in the first Annual Report required in paragraph 53.

HIP POWER Accounts

34. **General Description.** The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and will, at a minimum, be funded with state, federal, and enrollee contributions. Employers may contribute as well, with some restrictions.

POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. Enrollees will be informed that responsible use of POWER Account funds, as well as utilization of recommended preventive care services, can lead to a reduced financial burden in the subsequent years. If enrollees are aware that prudent management of their health care expenditures can leave them with available funds at the end of the year—and that these funds can be used to lower the following year's contribution—enrollees will be encouraged to make value- and cost-conscious decisions.

Enrollees will make the same POWER Account contribution regardless of the delivery system under which they receive benefits. The amount of annual POWER Account

contributions is based on family size and income. Family income will be determined under the methodology applicable to the group under the state Medicaid plan. The enrollee's coverage will begin on the first of the month after his or her first POWER Account contribution is received and processed.

Therefore, individuals eligible for HIP are deemed "conditionally eligible" until they make their first POWER Account contribution. Eligibility does not become final until the individual has made their first POWER Account contribution and, if the payment is made by check, the check clears to the MCO or ESP.

35. **Required Enrollee Participation in a POWER Account.** HIP enrollees are required to help fund the $1,100 deductible by contributing to a POWER Account. Contributions will be determined on a sliding scale based on the enrollee's family income, so that POWER account contributions when added to other payments made by the enrollee's family to CHIP, Medicaid or Hoosier Healthwise will not exceed 5 percent of an enrollee's gross annual family income. Enrollee contributions will be reduced by the amounts of employer or non-profit contributions made to the POWER account on behalf of the enrollee.

    a. The sliding scale for POWER Account contributions is as follows:

Table 4 – POWER Account Contributions

Annual Household Income	Maximum POWER Account Contribution
All enrollees at or below 100 percent FPL	No more than 2 percent of income
All enrollees above 100 through 125 percent FPL	No more than 3 percent of income
All enrollees above 125 through 150 percent FPL	No more than 4 percent of income
HIP Caretakers above 150 through 200 percent FPL	No more than 4.5 percent of income
HIP Adults above 150 through 200 percent FPL	No more than 5 percent of income

    b. The state will develop an algorithm to determine the amount of an enrollee's annual required contribution and will notify the MCO and ESP of this amount. The MCO and ESP must bill for, and collect, the required enrollee contribution.

    c. Enrollees must be given the opportunity to pay their required contribution in equal monthly installments.

36. **Enrollee POWER Account Contributions.** The state will notify new enrollees of POWER Account contribution requirements at the same time the state informs new enrollees that they have been found "conditionally eligible."

    a. **Initial Enrollee Contribution.** The first installment will be due 60 days after the enrollee is enrolled into an MCO or ESP, and may not exceed one-twelfth (1/12) of the enrollee's total required annual POWER Account contribution. HIP coverage will not begin until the first day of the coverage month after the first POWER Account contribution installment is received, or, if payment is made by check, the check clears.

The MCO or ESP must notify the state within 5 to 30 days after an enrollee's first POWER Account contribution installment has been received.

b. **Ongoing Monthly POWER Account Contributions.** In families with two enrolled individuals, each enrollee will have their own POWER Account. However, the total of both enrollees' POWER Account contributions cannot exceed the total POWER Account contribution that applies to the family's annual household income as specified in paragraph 35(a).

c. **Recalculation of Enrollee POWER Account Contribution Amount**. At the end of each coverage term and after the enrollee has been determined eligible for another coverage term, the enrollee's POWER Account contribution may need to be recalculated for the new coverage term, based on changes in the enrollee's annual household income identified at the time of redetermination.

   The state will notify the MCO or ESP of the enrollee's POWER Account contribution for the new coverage term, and within 60 days, the MCO or ESP will:

   i. Reduce the enrollee's POWER Account contribution for the new coverage term by the amount of the enrollee's POWER Account balance that was carried forward as calculated in paragraph 42(c);
   ii. Notify the enrollee of this roll-over amount, as well as the new amount to be billed to the enrollee in equal monthly installments in the new coverage term; and
   iii. Reconcile any overpayments or underpayments made by the enrollee as a result of the overlapping timeframes of monthly payments and recalculation of new contribution amounts for the new coverage term.

37. **State POWER Account Contributions.**

   a. The state will fund any gap between a non-ESP enrollee's annual required POWER Account contribution and the $1,100 deductible. The state will make its <u>entire</u> contribution to the POWER Account promptly after receiving notice from the MCO that the enrollee's first POWER Account contribution has been received and processed.

   b. The state may choose whether or not to fund the gap between an ESP enrollee's annual required POWER Account contribution and the $1,100 deductible, following requirements addressed in paragraph 25.

38. **"Up -Front" POWER Account Contribution by MCO or ESP.**

   a. In the case where a covered service may exceed the member's current POWER Account balance, the MCO or ESP must reimburse the provider for the balance according to its normal claims processing procedures. The MCO or ESP can recover the funds it paid on the member's behalf with future POWER Account contributions paid by the member.

b. If an enrollee is terminated under the provisions in paragraphs 43 and 45 before the full annual POWER Account contribution is paid to the MCO or ESP, the MCO or ESP will levy the enrollee's account and notify the state of the enrollee's debt.

c. The MCO or ESP may attempt to collect the unpaid POWER Account contributions from the enrollee, including reporting the debt to credit reporting agencies. However, the MCO or ESP may not "sell" the debt for collection by a third-party.

d. If the enrollee should reapply for HIP, after the mandatory 12-month waiting period specified in paragraphs 42 and 44, the enrollee must pay the prior POWER Account debt as well as the first month's contribution before services can begin.

39. **Employer Contributions**. Employers are permitted and encouraged to contribute to their employees' POWER Accounts. An employer's contribution must be used to offset the employee's required contribution only—not the state's.

40. **Not-for-Profit Contributions.** Not-for-profit organizations are permitted to contribute up to 75 percent of an enrollee's POWER Account contribution. A not-for-profit organization's contribution must be used to offset the enrollee's required contribution only—not the state's.

41. **POWER Account Card.** The MCO or ESP must issue a card to each enrollee promptly after processing the enrollee's first POWER Account contribution, within thirty (30) days. This card may have all POWER Account contributions loaded onto it.

a. An electronic account update will be e-mailed to the enrollee by the MCO or ESP each time a contribution is credited to the enrollee's POWER Account in order to reflect the new balance.

b. The card may be used by enrollees only to pay for covered services performed by network providers.

c. For covered services provided out-of-network, if the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's card, the MCO or ESP will reimburse the out-of-network provider with funds from the enrollee's POWER Account. ESP and the MCOs may also reimburse in network providers with funds from the enrollee's POWER Account if the network providers lack the capacity to conduct the transaction using the enrollee's card.

d. The MCOs and ESP are required to have an internal system of safeguards for the cards and to manage the POWER Accounts. The state will actively monitor plans and their management of the POWER Accounts either through a separate annual audit or will require the plans to fund annual independent audits.

42. **Use of POWER Account Funds.** Each enrollee will be responsible for the use of funds in

his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the enrollee to pay for the MCO's covered services, including any enhanced services the MCO may choose to offer.

a. **Out of Network Providers.** In spending POWER Account funds, enrollees will be permitted to pay for the following covered services, even if obtained through out-of-network providers:

   i. Family planning services;

   ii. Emergency medical services, subject to the prudent layperson standard of an "emergency medical condition," as specified in 42 CFR 438.114;

   iii. Medically necessary covered services, if the MCO's network is unable to provide the service within a 30-mile radius for primary care and a 60-mile radius for specialty care of the enrollee's residence; and

   iv. Nurse practitioner services.

b. **Payment for Out of Network Providers.** For the out-of-network services specified in subparagraph (a), the MCO must coordinate with the out-of-network provider to ensure that the cost to the enrollee is no greater than it would be if the services were provided in-network. If the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's POWER card, the provider must be instructed to bill the MCO and the MCO must reimburse the out-of-network provider with funds from the enrollee's POWER Account.

c. **Carry-Forward and Use of Excess Funds.** At the end of a 12-month coverage term, there may be funds remaining in a enrollee's POWER Account. Some or all of the funds remaining in an enrollee's POWER Account may be carried forward to the next coverage term to reduce the enrollee's required POWER Account contribution in that coverage term. The amount of leftover funds available to be carried forward will depend on several factors outlined below.

   i. If the enrollee has obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, the entire remaining POWER Account balance, including monies contributed by the state, will be carried forward. The enrollee's required contribution for the new year will be the amount determined using the state's algorithm (paragraph 35 (b)), reduced by the amount carried forward. If the amount carried forward is greater than the amount determined using the state's algorithm, the required contribution for the new coverage year is $0. For non-ESP enrollees, the state must then contribute to the POWER Account an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and $1,100.

ii. If the enrollee has not obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, only the pro rata share of the enrollee's portion of the POWER Account balance may be carried forward. The pro rata share of the enrollee's portion equals the amount the enrollee's required contribution for the expiring coverage term, plus any enrollee balances rolled over from previous coverage terms, multiplied by the unspent percentage of the POWER Account from the expiring term. The state's portion of the unspent POWER Account balance, calculated similarly to the enrollee's portion of the unspent POWER Account balance, must be returned by the HIP MCO to the state. The enrollee's POWER Account contribution for the next coverage term is the amount determined using the state's algorithm (paragraph 37(b)), minus the amount carried forward as calculated above. The state must contribute an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and $1,100. The state may collapse the recovery of the state share of the POWER Account balance and its contribution for the next coverage term into a single, net transaction.

iii. If the amount of funds available to be carried is in excess of the enrollee's required POWER Account contribution for the next coverage term, the excess amount will be credited to the state to reduce the state's contribution in the next coverage term. This shall occur regardless of whether or not the enrollee obtained his or her recommended preventive care services.

iv. The HIP MCOs and ESP must develop and maintain accounting systems capable of tracking POWER Account balances and sub-balances according to whether they were initially contributed by the enrollee or the state. POWER Account balances must maintain their identity as enrollee or state contributions throughout the process.

43. **Non-Payment of Monthly POWER Account Contribution.** If an enrollee does not make a required monthly contribution within 60 days of its due date, the enrollee will be terminated from participation in HIP and disenrolled from the MCO or ESP. The enrollee will also forfeit 25 percent of the enrollee's pro rata share of funds remaining in the POWER account.

a. Before terminating the enrollee, the MCO or ESP must provide at least one written notice advising the enrollee of the delinquent payment, and the date by which the contribution must be paid to prevent disenrollment, as well as notice of the enrollee's appeal rights. The notice must be sent to the enrollee on or before the seventh day of delinquency and must state that the enrollee will be disenrolled from the MCO or ESP and terminated from participation in HIP if payment is not received prior to the date specified in the notice. The notice must explain that if the enrollee is terminated from participation in HIP, the enrollee will not be able to reapply for HIP coverage for a period of at least 12 months.

b. The MCO or ESP is required to refund the enrollee's pro rata portion of the POWER Account, which must be distributed to the enrollee no later than sixty (60) days after the

last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as follows:

i. Calculate the total enrollee contribution to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms (E^T);

ii. Calculate the amount actually contributed by the enrollee to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms (E^A);

iii. Calculate the percentage of the POWER Account expended during the coverage term, which will equal the total dollar amount expended, divided by $1,100 (u);

iv. Multiply the result in (iii) by the result in (i), and subtract from the result in (ii) ($R = E^A - u*E^T$).

v. If the result in (iv) is positive, the MCO or ESP must return 75 percent of this amount to the enrollee and 25 percent of this amount to the state.

vi. If the result in (iv) is negative, the result is the amount that the enrollee owes to the MCO or ESP as described in paragraphs 38 (b) through 38(d).

vii. The MCO or ESP must return to the state all unexpended state POWER Account contributions, including amounts carried forward from prior coverage terms.

44. **Loss of Eligibility for HIP and POWER Account Contributions.** If an enrollee becomes ineligible for HIP, either at redetermination or at another time, the MCO or ESP must refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as in paragraph 43(b), except that in step (v), 100 percent of the result must be returned to the enrollee.

45. **Failure to Redetermine Eligibility and POWER Account Contributions.** If an enrollee fails to complete all necessary steps to maintain eligibility for HIP at the end of a coverage term, the enrollee will not be permitted to reapply for HIP for a period of at least 12 months.

    The MCO or ESP will be required to refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO. The amount payable to the enrollee shall be determined using the calculations specified in paragraphs 43 and 44. Unspent state POWER Account contributions must be returned to the state.

46. **POWER Account Balance Transfers.** If an enrollee transfers to a new MCO or ESP, the enrollee's POWER Account balance will be transferred to the state within thirty (30) days from the date the MCO or ESP was notified by the state.

For a transfer at the end of a coverage term, the current MCO or ESP remains responsible for determining the amount of the enrollee's POWER Account that may be carried over, and forwarding that amount to the state. The state will forward the balance to the new MCO or ESP.

47. **POWER Account Reporting to State.** Each MCO and ESP must submit a report to the state each month that provides the following for each terminated or ineligible enrollee:

a. Demographic information on the enrollee;

b. The balance remaining in the enrollee's POWER account;

c. The amount paid to the enrollee as required under paragraphs 42 through 45; and

d. The amount to be returned to the state.

VII. GENERAL REPORTING REQUIREMENTS

48. **General Financial Requirements.** The state shall comply with all general financial requirements under title XIX set forth in these STCs.

49. **Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

50. **Compliance With Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR Part 438 *et seq.,* except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

51. **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

52. **Quarterly Progress Reports:** The state must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

c. Action plans for addressing any policy, administrative, or budget issues identified;

d. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population, as required to evaluate compliance with the budget neutrality agreement, and as specified in Section VIII, paragraph 57; and other statistical reports listed in Attachment A; and

e. Evaluation activities and interim findings including the number of individuals who are within $100,000 of reaching the annual or lifetime benefit limit. The state shall report on its efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.

f. A report on which option the state is currently using and any plans to change the option regarding state contributions to ESP enrollees' POWER Accounts as outlined in paragraph 25(b).

g. A list of services (including service codes) that are considered to be preventive services that can be provided from the $500 of "first dollar coverage," and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds as outlined in paragraph 42(c).

53. **Annual Report.**

a. The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

b. In addition, the state shall include information on the following in its draft annual report:

i. The level of preventive services compliance, including a summary of member compliance and non-compliance with Office of Medicaid Policy and Planning (OMPP) recommended preventive services.
ii. The number of HIP Caretakers and HIP Adults who are within $100,000 of exceeding the annual and or lifetime benefit limit and the state's efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.
iii. The progress of Indiana's care management program for the Aged, Blind, and Disabled (ABD) population and the feasibility of moving part or all of the ABD population into managed care.
iv. Any strategies the state is examining to reduce the uninsurance rate in the state, such as restructuring the Small Group Reinsurance Pool to make it more attractive to small groups.
v. Incentive programs developed by HIP MCOs for providers and HIP members. Potential areas include emergency room utilization, access to care, asthma, obesity, preventive service utilization, and smoking cessation.
vi. A description of how health information technology (HIT) is progressing in the state and how the demonstration has assisted in progressing HIT, including any HIT and data sharing initiatives that are developed or implemented by HIP MCOs to improve quality, efficiency, and safety of health care delivery in Indiana.
vii. A description of the process through which a HIP member may appeal the state's decision to move the member out of an MCO to ESP or out of ESP to an MCO as outlined in paragraph 25(e).
viii. A description of the process for ensuring that families do not exceed the 5 percent cost sharing limit as outlined in paragraph 33(c).
ix. A description of the type of services that are being paid for by POWER Account contributions broken down by gender, age and income level.

c. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year (DY) for CMS review. The state shall finalize and submit the final draft report within 60 days from receipt of CMS' comments.

VIII. GENERAL FINANCIAL REQUIREMENTS

54. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.

55. **Reporting Expenditures Under the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Indiana must report demonstration expenditures through the MBES and state Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning January 1, 2008, and ending December 31, 2008. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base. Expenditures for HHW Caretakers, HHW Children, and HHW Pregnant Women with dates of service December 31, 2007, and before, but with dates of payment January 1, 2008, and after, should be reported on Forms CMS-64.9 Base and 64.9P Base.

b. **Reporting of HIP Plan Premiums and POWER Account Contributions** The state must report HIP plan premiums and POWER Account contributions as follows:

   i. HIP MCO Premiums. HIP plan premiums must be reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver, using Line 18A.
   ii. State's Contributions to Participants' POWER Accounts. The state's contributions to participants' POWER Accounts must be reported on Forms CMS-64.9 Waiver, using Line 18E. (Because individual participants' POWER Account contributions are collected by the HIP plans, and are not subject to federal matching, they are not to be reported on the CMS-64.)
   iii. Recouped State Contributions to Participants' POWER Accounts. In the event that the state recoups state POWER Account contributions from HIP MCOs (for example, when a participant disenrolls from HIP; see paragraphs 42.c.ii., 43.b.vii., 44, 45, and 46), the amounts collected must be reported as a prior period adjustment using Line 10B of the Forms CMS-64.9P Waiver on Line 18E.
   iv. Forfeited Participant Contributions. In the event that a participant's eligibility for HIP is terminated for non-payment of POWER Account contributions, resulting in forfeiture of 25 percent of the remainder of the participant's share of their POWER Account balance (see paragraph 46(b)(v)), the state must recover the forfeited funds from the HIP MCO and must report the recovery as a collection on Form CMS-64, Line 9D. The state must also provide a supplementary report on the Narrative section of Form CMS-64, stating the amount reported on Line 9D attributable to the recovered participant POWER Account balances, along with a disaggregation of the amount reported by eligibility group, as specified in subparagraph (d).
   v. Service Expenditures Through ESP. Expenditures for health care services provided through ESP other than those funded through state or enrollee POWER Account contributions, must be reported on CMS-64.9 Waiver and CMS-64.9P Waiver, by eligibility group, on the appropriate service line. In addition, expenditures for

administrative services provided through ESP must be reported on CMS-64.10 Waiver and CMS-64.10P Waiver, by the appropriate eligibility group—"ESP Caretakers Adm" or "ESP Adults Adm," as described in subparagraph (g) below.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid Manual.

d. **Use of Waiver Forms**. The following five (5) waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

   i. "HHW Caretakers" expenditures

   ii. "HHW Children" expenditures

   iii. "HHW Pregnant Women" expenditures

   iv. "HIP Caretakers" expenditures

   v. "HIP Adults" expenditures

e. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to all title XIX expenditures on behalf of individuals who are enrolled in this demonstration, as defined in Section IV, paragraph 16, including all service expenditures net of premium collections and other offsetting collections. All title XIX expenditures that are subject to the budget neutrality expenditure limit are

considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Administrative Costs.** The following provisions govern reporting of administrative costs during the demonstration.

   i. In accordance to federal regulations at 42 CFR 488.812(b)(2), the portion of the state's payments to ESP that is for administrative services must be claimed by the state as an administrative cost at the federal matching rates available for the costs of administration of the Medicaid program. These administrative expenses are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit described in section IX of these STCs. These administrative costs must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY for which the administrative services were paid. Separate forms must be submitted, using the waiver name "ESP Caretakers Adm" to report expenses related to the management of HIP Caretakers' services, and "ESP Adults Adm" to report expenses related to the management of HIP Adults' services.

   ii. Administrative costs attributable to the demonstration that are not described in (i) must be reported under waiver name "HIP." These expenses are not subject to the budget neutrality limit.

   iii. Administrative costs not related to the demonstration should be reported on the appropriate CMS-64.10 Base or 64.10P Base, or another waiver schedule as appropriate, and not subject to the budget neutrality test for this demonstration.

h. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

i. **Mandated Increase in Physician Payment Rates in 2013**. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013, with the federal government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of

separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date.

56. **Reporting Expenditure Reconciliation and Limitations.**

    a. The state must take corrective action to ensure that expenditures subject to the budget neutrality limit are reported in a manner that conforms to the requirements outlined in paragraph 55 of these STCs. Specifically, the state must submit prior period adjustments, using Form CMS 64.9P Waiver as needed, to ensure that net expenditures for health care coverage for the demonstration population are correctly reported by DY according to dates of service, which will be summarized on the C Report. This applies to expenditures for DY 1 through 5. The state must complete this action by March 31, 2013.

    b. **Time Frame and Limitations** – The state must complete the reconciliation process by March 31, 2013, and the corrections must be reported on the CMS-64 report for the quarter ending December 31, 2012. The state may not amend the demonstration as defined in paragraph 7 until the expenditure reconciliation process is complete.

    c. **Application of the Penalty.** The state will be required to reimburse the federal share of all demonstration related expenditures if the result of expenditure reconciliation process determines that the demonstration is not budget neutral during the prior approval period (DY 1 through DY 5).

57. **Reporting Member Months:** The following describes the reporting of member months for HIP:

    a. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the quarterly report required under Section VII, paragraph 52, the actual number of eligible member months for all HIP eligibility groups defined in Section IV, paragraph 16. The state must submit a statement accompanying the quarterly report, certifying the accuracy of this information. Member months should be reported only for individuals who are participating in the demonstration, as defined in Section IV, paragraph 16.

       A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for "HHW Caretakers," "HHW Children," "HHW Pregnant Women," and "HIP Caretakers" are reported in section 6A of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for "HIP Adults" are reported in section 6B of the template, and are not used to calculate the budget neutrality expenditure limit.

    b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible

for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member months.

c. "Eligible member months" does not include the number of months in which an individual participating in the demonstration cannot access services as a result of reaching the lifetime benefit limits outlined in Section VI, paragraph 34.

58. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

59. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section IX.

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities;

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

60. **Sources of Non-Federal Share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the HIP reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

d. FFP will not be available for individual contributions to the POWER Accounts. FFP will be available for state contributions to the POWER Accounts, payments to MCOs, and service expenditures through ESP. Payments to the MCOs are based on the assumption of a $1,100 deductible.

61. **Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

62. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, and is determined by using a per capita cost method, with an aggregate adjustment for projected DSH payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section VIII, paragraph 55.

63. **Risk.** Indiana shall be at risk for the per capita cost (as determined by the method described below in this Section) for Medicaid eligibles in the following eligibility groups: "HHW Caretakers," "HHW Children," "HHW Pregnant Women," and "HIP Caretakers," but not for the number of demonstration eligibles in each of the groups. By providing FFP for HIP enrollees in these eligibility groups, Indiana shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Indiana at risk for the per capita costs for HIP enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Indiana will be at risk for both per capita costs and enrollment for "HIP Adults" eligibles.

64. **Budget Neutrality Annual Expenditure Limits.** For each DY, two annual limits are calculated.

a. **Limit A.** Limit A consists of the sum of three components. Components one through three are calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 58) for "HHW Caretakers," "HHW Children," "HHW Pregnant Women," each multiplied by the Composite federal Share (defined below). Component four equals three-quarters of Indiana's federal share DSH allotment for the FFY that ends during the DY, minus $113,387,550 (federal share). Component five equals one-quarter of Indiana's federal share DSH allotment for the FFY that begins during the DY, minus $37,795,850 (federal share). Components four and five are only applicable to DYs 1 – 5.

b. **Limit B.** Limit B is calculated as the projected PMPM cost times the actual number of member months for "HIP Caretakers," multiplied by the Composite federal Share.

c. **PMPM Costs.** The following table gives the projected PMPM costs for the calculations described above by DY.

	Trend	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**	**Trend**	**DY 6**
HHW Caretakers	4.40%	$328.07	$342.50	$357.57	$373.30	$389.73	4.40%	$406.88
HHW Children	4.40%	$180.51	$188.45	$196.74	$205.40	$214.44	4.40%	$223.88
HHW Pregnant Women	4.40%	$476.17	$497.12	$519.00	$541.83	$565.67	4.40%	$590.56
HIP Caretakers	4.40%	$312.59	$326.34	$340.70	$355.69	$371.34	4.40%	$387.68

d. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the 5-year approval period, as reported on the forms listed in paragraph 55(d), by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the 5-year approval period (see paragraphs 9, 10, and 12), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

65. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under HIP.

66. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, by combining the annual limits calculated following paragraph 64 into lifetime limits for the demonstration. The following describes how budget neutrality will be enforced.

    a. Test A consists of application of the combined annual Limits A to demonstration spending reported on the following schedules, as defined in paragraph 55(d) and 55(f): "HHW Caretakers," "HHW Children," "HHW Pregnant Women," "HIP Adults," "ESP Adults Adm."

    b. Test B consists of application of the combined annual Limits B to demonstration spending reported on the "HIP Caretakers" and "ESP Caretakers Adm" schedule.

    c. If Test A expenditures exceed Limit A, the state must refund excess expenditures from Test A to CMS. Test B savings cannot be used to offset excess expenditures from Test A.

    d. If Test B expenditures exceed Limit B and Test A shows savings, a second test is performed by combining Tests A and B. The state must refund excess expenditures (if any) from the combined test to CMS.

    e. If both Tests A and B show excess expenditures, the state must refund the excess expenditures from both tests to CMS.

    f. If the demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the state's compliance with these requirements shall be based on the time elapsed through the termination date.

    g. **Interim Checks/Corrective Action Plan.** If the state exceeds the calculated cumulative target limit for both Tests A and B combined by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 1	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 2	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 3	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 4	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 5	Cumulative budget neutrality expenditure cap plus:	0 percent
Year 6	Cumulative budget neutrality expenditure cap plus:	0 percent

X. EVALUATION OF THE DEMONSTRATION

67. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after the effective date of the demonstration. At a minimum, the draft design must

include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The state shall ensure that the draft evaluation design will address the following evaluation questions:

1. How many HIP participants reach their $300,000 annual benefit limit each year? How do these individuals meet their health care needs during the period of exhaustion of their benefit and the beginning of the next coverage term?
2. How many HIP participants reach their $1,000,000 lifetime benefit maximum? How do they go about meeting their health care needs after their HIP benefits are exhausted?
3. What are the consequences of limiting participants' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCO?
4. How many enrollees are reassigned from HIP MCOs each year to ESP? How many are reassigned from ESP to a HIP MCO?
5. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
6. What are the consequences of requiring HIP participants with family income less than 150 percent of the FPL to pay monthly premiums? How many of these participants fail to make their first POWER Account contribution? How many of these participants are disenrolled for failure to pay their premiums?
7. To what extent has HIP impacted the uninsurance rate in Indiana?
8. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
9. How many enrollees exhaust their POWER Account each year? How many enrollees are able to roll-over a sufficient POWER Account balance to reduce their subsequent year's required contribution by at least half? How many enrollees are able to achieve a $0 contribution by this means?

68. **Interim Evaluation Reports**. In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

69. **Final Evaluation Design and Implementation**. CMS must provide comments on the draft evaluation design within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The

state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

70. **Cooperation with Federal Evaluators**. Should CMS undertake an independent evaluation of any component of the demonstration, the m shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

XI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date – Specific	Deliverable	STC Reference
3/31/2013	Reporting Expenditure Reconciliation Action	Section VIII, paragraph 56
6/30/2013	Submit Demonstration Extension Request	Section II, paragraph 8
6/30/2013	Submit Interim Evaluation Report	Section X, paragraph 68

	Deliverable	STC Reference
[redacted]		
Annual	By May 1st - Draft Annual Report	Section VII, paragraph 53
[redacted]		
Quarterly		
	Quarterly Progress Reports	Section VII, paragraph 52
	Quarterly Expenditure Reports	Section VIII, paragraph 54
	Eligible Member Months	Section VIII, paragraph 57

Under Section VII, paragraph 52 of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Healthy Indiana Plan Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (1/01/08 - 12/31/08)
Federal Fiscal Quarter: 2/2008 (1/08 - 3/08)

Introduction:
Information describing the goal of the demonstration, what it does, and key dates of approval/ operation. (This should be the same for each report.)

Eligibility and Enrollment Information:
Please provide the following information. If there was no activity under a particular facet of the tables below, the state should indicate that by "0."

1. The number of HIP members who have reached $200,000 in benefits in a year or $900,000 in benefits in a lifetime. Of these individuals, how many have been referred to the regular Medicaid program, Medicaid for Employees with Disabilities (M.E.D. Works), or ICHIA, the state's high-risk pool.

2. The number of HIP members who have reached the $300,000 annual and $1 million lifetime benefit limits during the quarter. Of these individuals, how many were determined eligible for the regular Medicaid program, and thus have continued coverage available despite having reached their coverage limit? Of these individuals who were not determined eligible for regular Medicaid, how many were determined eligible for M.E.D. Works, and how many were determined eligible for ESP?

3. The number of HIP enrollees who are receiving benefits through ESP.

4. Report on the number of HIP applicants and the disposition of their applications, by income relative to FPL, using the following table:

FPL Level	Column A: Number of Hoosier Healthwise or HIP Applicants	Column B: Number enrolled in the Hoosier Healthwise program	Column C: Number enrolled with a HIP MCO	Column D: Number enrolled in ESP	Column E: Number of enrollees who failed to make POWER Account contribution and were terminated.	Column F: Number of applications declined due to a finding of ESI access or health insurance in the last 6 months
0-22% FPL						
22-50% FPL						
50-100% FPL						
100-150% FPL						
150-200% FPL						

5. Report on HIP enrollment numbers using the following table:

FPL Level	Column A: Number of persons enrolled at start of quarter	Column B: Number of persons enrolled during quarter	Column C: Number of persons disenrolled for non-payment of POWER Account	Column D: Number of persons disenrolled at end of coverage term for failure to recertify	Column E: Number of persons disenrolled for other reasons	Column F: Number of persons enrolled in HIP at the end of the quarter (F)=(A)+(B)-(C)-(D)-(E)
0-22% FPL						
22-50% FPL						
50-100% FPL						
100-150% FPL						
150-200% FPL						

6. Report member-months for budget neutrality:

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
HHW Caretakers				
HHW Children				
HHW Pregnant Women				
HIP Caretakers				

B. Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
HIP Adults				

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the state's actions to address these issues.

Consumer Issues:
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:

STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Michael R. Pence
Governor

February 13, 2013

The Honorable Secretary Kathleen Sebelius
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius,

On behalf of the citizens of Indiana, I respectfully submit this application to extend the Healthy Indiana Plan 1115 demonstration through 2016. We in Indiana believe strongly that this program, which has achieved wide bipartisan support, should continue given its track record of innovation and results.

As I have said in the past, I believe that the Healthy Indiana Plan should serve as the starting point for all future discussions of health care reform in Indiana. While our administration has committed to fully funding Indiana's current Medicaid forecast, we believe that expanding coverage absent significant reforms would not be in the best interest of Hoosiers.

Accordingly, our administration will not pursue an expansion of traditional Medicaid as permitted under the Affordable Care Act. To do so, in my view, would be to expand a highly flawed program in Indiana and place an enormous burden on Hoosier taxpayers. The people of our state deserve better.

The Congressional Budget Office projects that an expanded program will more than double annual federal Medicaid expenditures to $578 billion by 2023. In Indiana, an expansion of traditional Medicaid under the Affordable Care Act would cost our taxpayers upwards of $2 billion over the next seven years.

Medicaid is broken. It has a well-documented history of substantial waste, fraud and abuse. It has failed to keep pace with private market innovations that have created efficiencies, controlled costs, and improved quality. It has done little to improve health outcomes and does not adequately reimburse providers. Its burdensome rules and unwieldy regulations do not allow states to effectively manage their programs.

As you know, a number of creative proposals exist for granting states greater flexibility to tailor innovative Medicaid programs to meet the specific needs of their citizens. Block grants such as the Healthy Indiana Plan are a key tool in this regard. Greater flexibility would help states create and manage programs consistent with their local values and overcome the bureaucratic and inefficient nature of traditional Medicaid.

Our administration would predicate any expansion of Medicaid in Indiana on our ability to promote Hoosier innovation in the Healthy Indiana Plan to the expanded population. The Healthy Indiana Plan has significantly increased preventive services among its enrollees. It has empowered them to make better decisions affecting their health, dramatically reduced emergency room visits, and given them more "skin in the game." As a result, 94 percent of Healthy Indiana Plan enrollees say they are satisfied with the program, and 99 percent say they would re-enroll.

I would welcome the opportunity to meet with you to discuss how like-minded governors in statehouses across the country can work together with the Obama administration and Congress to grant more freedom and flexibility to states that want to improve Medicaid, as we do here in the Hoosier State.

It is in this spirit of cooperation that I submit our application for the continuation of the Healthy Indiana Plan. We look forward to hearing from you.

Sincerely,

/S/

Michael R. Pence
Governor of Indiana

Michael R. Pence, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Debra F. Minott, Secretary

"People helping people help themselves"

April 11, 2013

Cindy Mann, JD
Deputy Administrator and Director of CMCS
Center for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244

Dear Director Mann:

I am writing to provide an update and supplement to the waiver application we previously submitted to you on February 13, 2013, referenced as the Healthy Indiana Plan (HIP) waiver renewal request 2014-2016.

As you may recall from the phone conversation we had a few weeks ago, I explained that we had submitted the application prior to conducting public hearings in order to provide you and your team additional time to review it. The Indiana Family and Social Services Administration (FSSA) held two public hearings on March 20 and March 22, 2013. The process complied fully with the final federal 1115 waiver submission rnles. A summary of the stakeholder feedback is included as an attachment to this letter and shall serve as a supplement to our waiver application.

Many stakeholders testified in support of HIP's consumer-driven model which has been offered to enrollees over the past five years. HIP has proven to be a successful and popular program in our State, and we urge your positive consideration of our application. My team stands ready to continue our discussions on HIP. We look fo1ward to hearing from you.

Sincerely,

/s/

Debra F. Minott
Secretary

Indiana Family and Social Services Administration

Healthy Indiana Plan 1115 Waiver Extension Application

Submitted
4/12/2013

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Section 1: Introduction

Indiana seeks federal approval to continue and expand its successful waiver program, the Healthy Indiana Plan (HIP). HIP's innovation has proven that redesigning Medicaid to empower and engage participants to be consumers of health care can have a dramatic impact on utilization and outcomes. In 2010, and prior to the Supreme Court of the United States ruling which makes Medicaid expansion optional under the Patient Protection and Affordable Care Act (PPACA), the Indiana Legislature passed Senate Enrolled Act 461 (Indiana Code 12-14-44.2), calling for HIP to be the coverage vehicle for the newly eligible Medicaid expansion population under the PPACA. While, the State has not yet committed to a Medicaid expansion, we seek approval to use HIP as the coverage vehicle should the state move forward with expansion.

In September 2012, CMS granted a one-year extension of the groundbreaking Healthy Indiana Plan 1115 waiver demonstration. The program now expires in December 2013 and, per the Centers for Medicare and Medicaid Services (CMS) guidelines, the State submits this subsequent request to extend the program beyond 2013 for the maximum waiver renewal period of 3 years. The issues presented in this waiver request are not new and Indiana has brought these issues to CMS since 2010. Therefore, we request prompt resolution so policy makers can understand the future of the HIP program. If CMS does not give Indiana permission to continue the program, the State will need at least six months to halt future enrollment and dismantle the current program.

The waiver application is materially identical to our December 2011 submission. It has been updated to reflect the Supreme Court decision which makes Medicaid expansion optional, data updates over the past year have been provided, and a preliminary analysis of the Essential Health Benefit requirements as they relate to Medicaid benchmarks has been included.

Section 2: Background and Program Description

The initial HIP demonstration project was approved in December 2007, and the program began January 1, 2008. Through the current demonstration year, HIP covers caretaker and non-caretaker adults up to 200% of the federal poverty level (FPL).[1] HIP represents one of the first Medicaid demonstration projects that worked towards harnessing the promise of consumerism through member participation to incentivize positive health behaviors and improve health outcomes. The program created Personal Wellness and Responsibility (POWER) accounts modeled after Health Savings Accounts (HSA) to encourage enrollees to be consumers of health care services that evaluate cost and quality. Five years later, HIP has demonstrated significant success in achieving its goals and remains the sole Medicaid demonstration project modeled on the principals of consumer-driven health plans.

In 2010, the Indiana Legislature passed Senate Enrolled Act 461, which became Indiana Code (IC) 12-15-44.2. This legislation adds a requirement for enrollees to make a minimum contribution to their POWER

[1] Caretakers are a categorically eligible Medicaid population; these individuals have a dependent under the age of 19. Non-caretakers are adults without dependents under the age of 19 that the HIP waiver grants the State permission to cover to an enrollment cap of 36,500 individuals, contingent upon the waiver's budget neutrality agreement.

account of $160 annually, allows not-for-profits to make up to 75% of the members required contribution to the POWER account, authorizes Managed Care Entities (MCEs) to contribute to the POWER account to incentivize positive health habits, and lowers the FPL allowed for HIP eligibility. The $160 annual contribution will still be subject to requirements in IC 12-15-44.2 that stipulates that enrollees may not spend more than 5% of their income in contributions and copayments for health care; for individuals who reach the 5% limit contribution requirements will be suspended.

In December 2011, a 3 year extension request was submitted for the HIP program. This request was approved for a one year period in September 2012. CMS has indicated it will not allow the minimum contribution for this one year period in 2013, but we repeat this request in consideration for 2014 and beyond. Our data indicates that making contributions does not deter individuals from needed care, but does lead to more appropriate utilization behavior[2].

HIP demonstrates that requiring contributions of members results in significant differences in utilization behavior. Within HIP itself, differences in care utilization have been observed between members who contribute to their POWER account and members who do not contribute, suggesting that making a contribution impacts healthcare consumption behavior. Non-contributors overall have a significantly higher use of Emergency Room (ER) services and non-emergency ER visits that could be partially attributed to not having to pay into POWER accounts or make co-payments for non-emergency ER use. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members.[3] The non-contributing population in general suffers from higher morbidity;[4] however, the POWER account contributions and the influence of consumerism cannot be ruled out as factors contributing to this vast difference in utilization.

Over the first four demonstration years, HIP has realized success. Between January 2008 and December 2011, HIP served 90,034 Hoosiers. In two separate independent evaluations of the program, HIP members have indicated a high level of satisfaction with their coverage and member satisfaction surveys conducted by the contracted health plans also show satisfaction rates consistently greater or comparable to commercial plans. The HIP program has noted differences in care utilization patterns compared with traditional Medicaid programs, including greater use of preventive care, lower ER usage, and increased utilization of generic pharmaceuticals. Eighty-percent of HIP enrollees complete the preventive services required for a POWER account rollover and, on average, over the first 12 months of enrollment HIP member non-emergency utilization of the ER decreases by 14.8%.[5]

HIP policies to promote personal responsibility have also had a positive impact. HIP incents individuals to obtain preventative health care by allowing the entire balance (State and individual contribution) of their POWER Account to rollover to the next benefit period, reducing their required contribution for the

[2] Mathematica 2010 Survey of HIP Members

[3] Data from Mathematica Data Enclosure, December 2010.

[4] *ibid.*

[5] Data from Mathematica Data Enclosure, December 2010.

following year. To this end, members have engaged in positive health behaviors including seeking preventive services at rates higher than comparable Medicaid populations, decreasing their non-emergency use of the ER, and increasing their utilization of services offered by primary care physicians. HIP members are actively aware of their POWER account balance and are supportive of the program: 94% are satisfied or highly satisfied with their coverage, and 99% of HIP enrollees would choose to reenroll in the program.[6] Survey data collected by Mathematica in 2010 suggests that the majority of respondents knew key features of the program. For example, most HIP members were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it.

Personal responsibility is the keystone of the HIP program. HIP policy requires that individuals make their monthly contributions within 60 days or face expulsion from the program for 12 months. Members must also return their redetermination packets on time, or face dismissal from the program. The vast majority of members pay their POWER account contribution on time, and during the first two years of the program only 3% of enrollees were disenrolled for failing to pay their POWER account contributions after enrollment. While this number grew to 8% of enrollees in 2010 and 9% of enrollees in 2011[7], it has remained steady at 9% of the total terminations from HIP through October 2012. In addition to POWER account payments, enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85% of HIP enrollees submitted redetermination packets on time. For the third year of the demonstration, 2010, 96% of enrollees submitted their redetermination packet on time. This trend continues and at least 91% submitted timely in 2011 and 92% submitted timely in 2012. These results suggest that HIP's policies encourage members to engage in their health care and that the members value the program.

Eligibility and budget neutrality requirements would remain the same in 2014, but the State requests that, as granted in the 1 year 2013 extension, disproportionate share hospital payments (DSH) not be diverted, since the State can achieve budget neutrality without these funds. With the expected changes in Medicaid eligibility in 2014, the caretaker and non-caretaker categories under HIP become the 'adult group';[8] and this waiver renewal application reflects the changes in the Final Rule on Medicaid program changes published in the Federal Register March 23, 2012.

HIP provides an alternative to traditional Medicaid and is the nation's first consumer-driven coverage program for low-income adults. HIP features a comprehensive high deductible health plan and a modified Health Savings Account (HSA) called the POWER account, which invites members to be thoughtful and engaged health care consumers. Contingent on payment of a monthly contribution to their POWER account, the current waiver provides HIP eligibility to Hoosiers between the ages of 19 and

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[6] Product Acceptance Research Telephone Survey of HIP members, 2009.

[7] In 2011 9% represented 1,843 individuals terminated for not paying a contribution after enrollment.

[8] As described by the *Medicaid Program: Eligibility Changes under the Affordable Care Act* final rule at 435.119.

64, earning below 200% FPL, who have not had access to employer sponsored insurance for at least six months.

As covering deductible costs is a known challenge for low income populations, HIP modifies the traditional HSA model to make it compatible with low income needs and limitations. First, the State subsidizes the POWER account to ensure the account is fully funded, up to the amount of the deductible. It requires health plans to provide payment to providers for deductible costs, even though the account may not contain the individual's full annual contribution. The State also ensures that the deductible is not a barrier to recipients receiving preventive services as the first $500 in preventive services are provided outside the deductible. While HIP contributions are not tax deductible, historically most participants are below federal poverty level and would not avail income tax benefits from tax deductible contributions.

After a $1,100 deductible is met through POWER Account funds, the HIP program includes comprehensive health plan benefits up to $300,000 annually and $1,000,000 lifetime which are waived from certain benchmark requirements.[9] Instead of traditional cost-sharing of premiums and copayments, HIP participants make upfront contributions for their health care through required POWER account contributions. The funds contributed to the POWER account are used to pay for deductible expenses. Contributions are based on a sliding scale so that individuals can afford to make the monthly payments but still have "skin in the game." The program ensures that no participant pays more than 5% of their income, consistent with CMS rules. Employers are also currently allowed to contribute up to 50% of the member's required contribution. Additionally, the renewal for 2013 allows not-for-profits to contribute up to 75% of the member contribution.

Participants have control over how POWER account dollars are spent and receive monthly statements on POWER account expenditures and account balances. If participants fail to make their contributions within sixty days, they are removed from the program and may not reenroll for twelve months.[10] Unlike traditional premiums or copayments, HIP members own their contributions and are entitled to any unused contributions if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by allowing any remaining balance-- including the State's contribution-- in their POWER account to rollover and offset required contributions in the next year. If individuals do not complete the required preventive services, only the pro-rated balance of their individual contribution rolls over. Any rollover amount can reduce required contributions in the following year. The incentive is designed to increase the use of preventive care. In the long term, the regular use of preventive services under the HIP program should reduce costs and improve the health of the individual members and total HIP population.

[9] HIP is not currently a benchmark plan due to the lack of maternity coverage, and the annual and lifetime coverage limits.

[10] Members are not considered enrolled in HIP until they have made their initial contributions, those that never make an initial contribution are not subject to the 12 month enrollment exclusion.

HIP provides comprehensive benefits including physician, inpatient, outpatient, mental health services, pharmaceuticals, labs, and other therapies. HIP requires copayments for non-emergency use of the emergency room; these copayments currently vary from $3 to $25 dependent on an individual's caretaker status and his or her federal poverty level (FPL) and cannot be paid out of the member's POWER Account. For this extension request copayment amounts are requested to be updated consistent with the January 2013 Cost-sharing NPRM. Different from traditional Medicaid programs, individuals are provided with monthly POWER Account statements and Explanations of Benefits that explain costs of care. These provisions are aimed at increasing member awareness of the cost of care and promoting consumerism and efficient care seeking behavior.

HIP promotes personal responsibility by requiring that members are timely with payments and eligibility paperwork submission; otherwise, enrollees face a twelve month penalty period before they may reenroll in the program. This also ensures that individuals do not enroll only when they are ill and require treatment and then drop coverage when they recover. HIP provides reimbursement to healthcare providers at Medicare rates, which in Indiana are higher than traditional Medicaid, thus encouraging a more robust provider network. These increased rates also improve enrollee access to care. HIP's progress towards meeting its program goals will be discussed later in this document.

Section 3: Historical Narrative

In 2006, Indiana ranked second in the nation for incidence of adult smoking, had poor general health indicators, and a low rate of preventive care utilization. Additionally in 2005, 860,000 individuals[11] had been without health insurance in the last year, and 62% of these uninsured were working age adults below 200% FPL.[12] Prior to HIP, the Indiana Medicaid program had one of the lowest eligibility thresholds in the nation and only covered non-disabled caretakers up to 23% of FPL. There was little support to expand the State's traditional Medicaid program as an open-ended entitlement that could strain the State's budget in future years Additionally, a traditional Medicaid plan had questionable ability to significantly improve the health status of individuals, a lack of incentives for participants to utilize health care appropriately, and the structure did not promote personal responsibility. While consumer driven health plans and HSAs were used in the commercial marketplace, they had not been used for low-income populations. Based on input from numerous stakeholder meetings, Governor Mitch Daniels instructed his staff to design a health care plan that incorporated health care consumerism and private market principles. This ensured the maintenance of a balanced State budget by not creating an open-ended entitlement program, and promoted health for Hoosiers.

Governor Daniels presented the design of the HIP program to the public in November of 2006. Once proposed, Republican State Senator Pat Miller and Democrat State Representative Charlie Brown championed the effort and sponsored House Bill 1678 during the 2007 session of the General Assembly. Through their leadership, the Indiana Check-Up plan, which contained the enabling legislation for HIP,

[11] U.S. Census Bureau, Current Population Survey (CPS), 3-year average, 2003-2005.

[12] State Health Access Data Assistance Center (SHADAC), University of Minnesota, *2003 Health Insurance for Indiana's Families Summary* (August 2003).

passed with bipartisan support with votes of 70-29 in the House of Representatives and 37-12 in the Senate. HIP's enabling legislation only permits the State to enroll as many individuals as its funding can support to ensure long-term budget sustainability. HIP enrollment is constrained by the number of dollars generated through a cigarette tax increase included in the enabling legislation that funds the program. This tax increase simultaneously discourages smoking and youth smoking in the State has declined since the passage of the law.

After the bill was passed in April 2007, the Family and Social Services Administration (FSSA) moved immediately to develop an implementation plan and began negotiations with CMS to obtain federal waiver approval. HIP began enrolling working-age, uninsured adults on January 1, 2008, seven months after passage of the enabling legislation and less than a month after receiving approval for the program from the CMS.

An unforeseen challenge of HIP was the pent-up demand for services in the uninsured population. Initially, the HIP population used services at a greater rate than the traditional Medicaid population, likely due to untreated disease in this previously uninsured population. However, since inception, HIP members have taken advantage of preventive services, lowered their non-emergency ER use, and learned to manage their chronic conditions through the use of prescription medications. Over the course of HIP, the program has met and exceeded the State's performance expectations. The State remains committed to HIP as a program that provides quality care to low income individuals while embracing the principals of consumerism.

In December 2011, after 4 successful years of administering HIP, the State submitted a 3 year waiver extension request. This request included changes to the HIP program including the addition of permitting not-for-profits to contribute to members POWER accounts, request for a minimum contribution, modifications to the budget neutrality agreements, and changes anticipating PPACA requirements beginning in 2014. In September 2012, a one year waiver extension request was granted though the minimum contribution requirements added to the HIP legislation in 2011 were not included in the approval.

3.1 Contract Modifications

HIP has evolved over the course of the demonstration. At the beginning of the program, HIP contracted with two MCEs, Anthem and MDwise, and had a third Enhanced Services Plan (ESP) that is separate but is operated by the State's high risk pool, the Indiana Comprehensive Health Insurance Association (ICHIA), to provide coordinated coverage for HIP members with high risk conditions. During the first three and a half years of the program, the contracts governing the State's relationship with Anthem and MDwise were modified to contain costs, better serve members, streamline ESP, and ensure that the MCEs remained on stable financial footing.

During the initial contracting period in 2007 the State selected two managed care plans Anthem and MDwise, in collaboration with AmeriChoice, that leveraged commercial experience and HSA experience. However, since then, MDwise has changed billing and claims subcontractors. Acting in some capacity as a third health plan option, ESP is administered on an Administrative Services Only basis through ICHIA. If

the HIP program continues, the State will consider another contractor for the HIP ESP program, as the ICHIA program will end in 2014 due to PPACA implementations.

In 2008, both Anthem and MDwise ended the year with losses as the capitation rates did not reflect the pent-up demand for services and high disease burden of a previously uninsured population. Non-caretakers in general had higher costs than caretakers. The State amended the risk-sharing arrangements in their 2009 HIP contracts. The amended contracts included higher monthly capitated rates for caretakers and a stop-loss provision for non-caretakers (effective retroactively to January 2009), and new criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009. The losses were due to the high morbidity of a previously uninsured population and pent-up demand of the early entrants, especially amongst the non-caretaker population where no Medicaid coverage existed. Actuarial analysis conducted on the first year of program claims experience showed that caretakers had a 25% higher risk adjusted relative morbidity than the commercial population, and non-caretakers had an even higher morbidity at 65% greater than a comparable commercial population. These populations also initially used services at a much higher rate, compared to a commercial population. Caretakers initially had 38% more inpatient hospital days and 181% more ER visits, and non-caretakers had 155% more inpatient hospital days and 269% more ER visits. Over the course of the first year of enrollment, HIP members increased their use of pharmacy services and decreased their use of all other services, with the decline in utilization beginning in approximately the third month of enrollment.[13] This pent-up demand for services has been challenging for health plans to manage. However, over the life of the program costs have decreased as the health plans have seen high inpatient costs replaced with more outpatient visits and use of prescription drugs.

The 2010 HIP contracts included a carve-out for most pharmacy services. The carve-out for pharmacy costs helped the State meet and exceed the budget neutrality requirements. The State consolidated into one contract all the pharmacy purchasing for Medicaid programs. This consolidation was done to maximize rebate savings available to the State, as well as to achieve administrative simplifications, and thus savings, on prescribing, dispensing, claims submission, program analytics, and prior authorization for pharmaceuticals. For members, this new arrangement provides access to an expanded list of pharmaceuticals, including brand-name pharmaceuticals. For providers, it streamlines the prescribing system, moving from multiple distinct lists of preferred drugs for different public programs and plans, to one list. This shift utilizes one set of prior authorization requirements, one claims processing methodology, and one help desk. Thus far, both vendors are working closely with the State and the State has established a good working relationship with these vendors.

The negotiations for the 2011 health plan contracts addressed the costs of care. Both Anthem and MDwise reported declines in utilization and more predictable costs now that the population has access to routine and preventive health care services.

[13] Damler, R. *Experience Under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured.* Milliman Inc. (August, 2009).

The 2011 contracts represented the first time the State combined HIP and Hoosier Healthwise (HHW) into one contract. HHW serves the State's non-waiver Medicaid managed care populations. The State's purpose is to integrate contracts to gain some program efficiencies and to make the programs seamless for families who have some members in HHW and others in HIP. As a result, the State views both programs as more family friendly. The new contract developed this integration and requires plans to maintain one call center for both programs -- a way of offering 'one stop shopping' to families with members in both the HIP and HHW programs. Unifying the programs also brings administrative simplification for providers, as the new contract aligns all policies and procedures in the two programs (although provider reimbursement remains based on Medicare rates in HIP). The State believes the new contracts will bring a focus on family health to both programs.

During the 2011 process the State selected three plans to serve the HIP population. Anthem and MDwise continue to serve HIP, and the State added Managed Health Services (MHS), which has traditionally served Indiana's Medicaid Hoosier Healthwise population. Under the new contracts, the plans must also implement a debit swipe card for HIP members. The cards are to be used at the point-of-service to verify eligibility, whether the service is covered, and whether the provider is participating in HIP. The card is linked to their POWER accounts, and members should be able to assess at the point of service what their contribution to the costs of the services will be (i.e., what will be deducted from their POWER accounts). All debit cards must make available the full $1,100.00 on day one of eligibility regardless of the current amount paid in by the member. The debit card is intended to enhance the experience of using the POWER account and promote consumer driven healthcare. MHS operationalized the card as of January 1, 2011 and the other plans followed later in the year. All debit cards were required to have the capability for eligibility determination and cost estimation as of July 1, 2011, with full implementation of the debit card in place by January 1, 2012. Both Anthem and MDwise issue a single swipe card that functions as their ID card and debit card, while MHS issues separate ID and debit cards. In the first two quarters of 2011, the health plans mailed flyers to their members along with the debit cards to educate the members on the benefits of utilizing the card.

No substantial changes occurred during 2012 or 2013 contract negotiations and contract negotiations have focused primarily on rates. HIP performance metrics and measures have not changed over these contracting periods.

3.2 Enhanced Services Plan (ESP)

The ESP was designed to reduce health plan risk and lower capitation rates. Initially, ESP participants were to represent the top 1% of risk in the HIP population. Through modifications to the ESP program this population currently represents the top 3% to 5% of risk in the HIP population. While receiving all the same HIP services and benefits, these high risk individuals are currently managed by the State's high risk plan, ICHIA, which has experience in managing high cost health conditions. The HIP population is separate from the State's high risk pool.

HIP's higher than expected initial cost of care, which partly resulted from pent-up demand and the higher morbidity and co-morbidities of a previously uninsured population, drove the State to identify ways of reducing the risk to the health plans. One means of attaining this goal was to expand the list of

conditions that would qualify an individual to participate in the ESP and simplify referral processes to make ESP determinations timelier. Originally, ESP was accessed when a high risk condition was reported and verified and the State contracted with a vendor to interview the patient to determine if the ESP placement was appropriate. To make access to ESP more convenient, the State altered several enrollment policies and expanded the list of qualifying conditions in July 2009. When HIP applicants check one of the qualifying conditions on the application, they are now automatically enrolled in the ESP and stay enrolled until their eligibility is redetermined. If their claims history at redetermination confirms the information reported on the application, they will stay with the ESP; otherwise, they will be transitioned to one of the other health plans. In addition, the plans now have six months to refer a member to the ESP, as opposed to 60 days in 2008. In July 2009, when the new policies took effect, Anthem and MDwise reviewed their claims records, applied Milliman's underwriting guidelines, and scored their members. Those members found to have an ESP qualifying condition and a risk score at or above a certain threshold were transferred to the ESP at that time. This process is expected to continue for the life of the waiver and no changes are requested. As the State's high risk pool will be eliminated in 2014, the State will identify a new vendor to manage the high risk individuals in the HIP program. Understanding the future of HIP will be critical to initiating this process.

3.3 Application Processing

At two different times during the first year of program operations, the State's vendor struggled to keep up with the flow of applications—more than 120,000 were submitted in CY 2008 (yielding more than 35,000 enrollees). At program initiation, high enthusiasm for the program, assertive outreach and advertising and pent-up demand led to more than 18,000 applications being submitted in just the first month. The State's vendor adjusted staffing to accommodate this initial surge in interest, but the queue again lengthened during the second half of 2008. Part of the challenge in managing applications may have been that HIP's launch coincided with a major initiative to upgrade enrollment and eligibility business processes affecting all public assistance programs operated by FSSA. To address the issue, additional eligibility staff was hired in January 2009. The application processing delays seen in the first demonstration year did not substantially slow enrollment. For example, by March 2009 HIP was approaching the enrollment cap (34,000) for non-caretaker adults, a level that the State had not expected to reach until the third or fourth year of the demonstration. To manage enrollment levels, and to ensure the State could maintain budget neutrality, the State closed enrollment for non-caretakers in March 2009.

The State also made significant progress in 2009 with the HIP application backlog. HIP operations staff worked to resolve various issues and have identified approaches to expedite their resolution. In late 2009, the State hired an additional 18 state eligibility consultants (SECs), who were brought on in January 2010. They have increased the percentage of applications processed in a timely manner from 71% in May 2009 to almost 91% as of September 2012. In the second quarter of 2009, the State developed a revised enrollment dashboard to include more information on the HIP application processing and to showcase different aspects of the HIP program. This dashboard continues to be used to manage application processing, however, for the application processing for HIP has operated smoothly since the changes made in 2010.

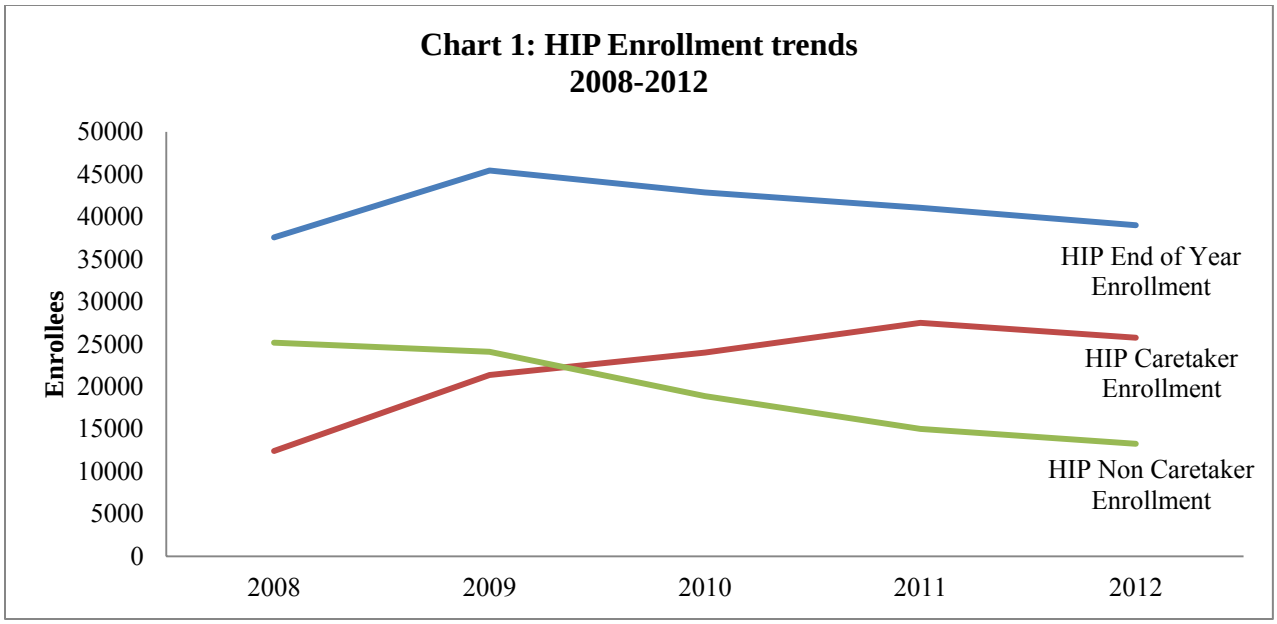
3.4 Non-caretaker Waitlist

The waiver agreement imposed a cap on the number of non-caretakers who could enroll in the program. On March 12, 2009, HIP closed enrollment to non-caretakers. At that time, the number of non-caretakers members had reached 32,000, just below the 34,000 cap established in the Special Terms and Conditions (STC). Enrollment for non-caretakers was closed before the cap was reached to ensure that applicants in the eligibility determination process or appealing denied applications and any pregnant woman who after delivering lost HHW eligibility could be enrolled in HIP without exceeding the cap. At the same time, all new applications from non-caretakers were reviewed for eligibility and placed on a waiting list if determined eligible. CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers. The State opened 5,000 non-caretaker slots in the fall of 2009 and sent letters to the first 5,000 applicants on the waitlist in November 2009. The invited applicants started the enrollment process by reapplying for HIP and having their eligibility for the program redetermined. With the passage of the Affordable Care Act in March 2010, HIP enrollment of non-caretaker adults remained closed due to the Maintenance of Effort (MOE) provisions contained in this legislation and a concern that, since the program could not be closed to caretakers, the State could be forced to cover costs beyond the funds that were available from the cigarette tax fund. Based on declining enrollment of non-caretakers, the State initiated the opening of an additional 8,000 slots to individuals on the waitlist in August 2011. The waitlist for non-caretakers was 46,388 as of the end 2012.

3.5 Enrollment Trends

From initiation through December 2012, the State received a total of 411,568[14] valid applications and 105,135 unique members had been enrolled. In 2008, the first year of program operations, the State received 120,313 total applications. Submitted applications dropped off in 2009 with 72,282 being submitted but picked back up again in 2010 with 117,252 submissions. The following year, 2011 saw 78,641 applications. The applications received in 2012 were substantially the same as 2011 and totaled 75,172.

[14] Valid applications exclude duplicate and incomplete applications received. HIP Dashboard December 2012.



The chart above shows the end of year enrollment trends for the first three years of the HIP program. The decline in non-caretaker enrollment and the increase in caretaker enrollment is apparent. HIP enrollment was 37,568 at the end of 2008, 45,460 at the end of 2009, 42,872 at the end of 2010 and current enrollment at the end of 2012 was 39,005. The program's population is divided into caretaker and non-caretaker groups. As the program has progressed the percentage of caretakers ever enrolled has increased in comparison to the non-caretakers enrolled. For those ever enrolled in HIP in 2010 56% were caretakers and 44% were non-caretakers. By comparison, at the end of 2008 67% of enrollees were non-caretakers and 33% of enrollees were caretakers. As of the end of 2012, 66% (25,746) of enrollees were caretakers and 34% (13,255) were non-caretakers.[15]

Over the course of the HIP program the majority of members have been under 100% FPL. Member distribution by FPL in December 2012 is consistent with the previous trend: 70% of HIP enrollees are currently at or under 100% FPL. HIP has consistently averaged only 10% of enrollees over 150% FPL.

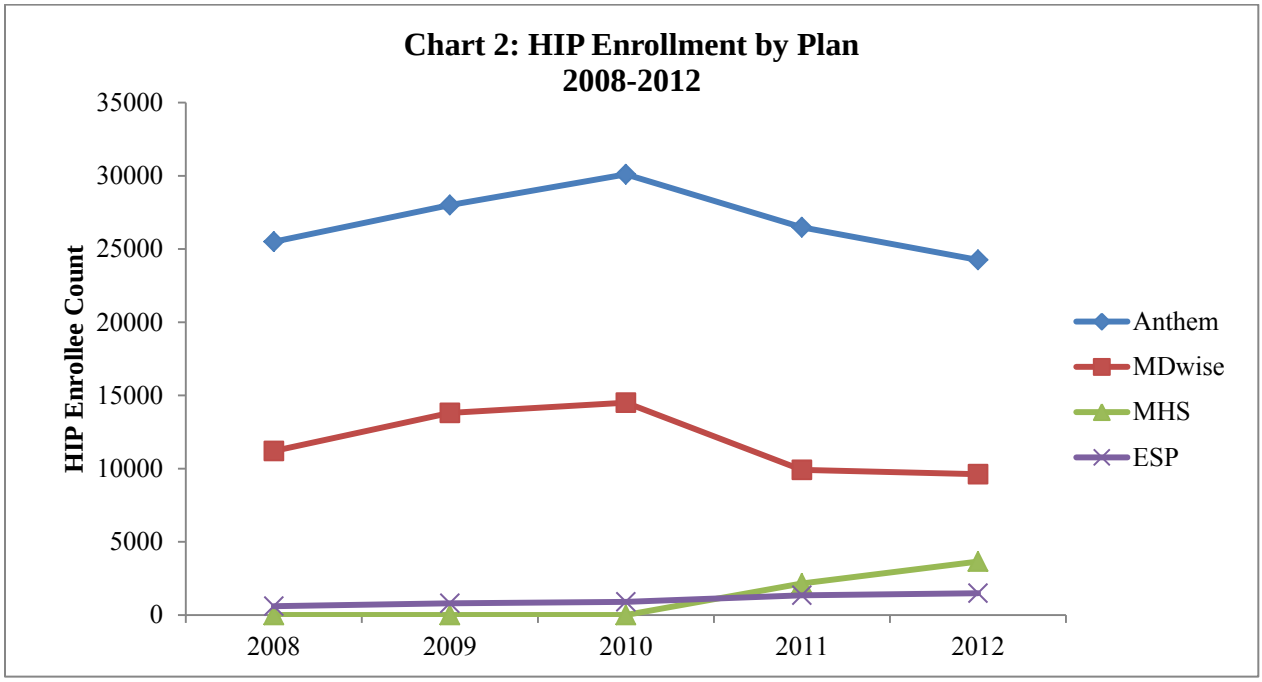
Table 1: HIP Enrollee Distribution by FPL[16]

FPL	2008	2009	2010	December 2011	December 2012
<100% FPL	26,969 72%	41,795 71%	37,061 62%	27,533 69.0%	27,276 69.9%
101 – 150% FPL	6,955 19%	11,432 19%	13,849 23.1%	8,288 20.7%	7,767 19.9%
>150% FPL	3,620 10%	6,079 10%	9,015 15%	4,075 10.2%	3,966 10.2%
TOTAL	**37,544 100%**	**59,306 100%**	**59,945 100%**	**39,896 100%**	**39,005 100%**

[15] Annual data from annual HIP reports. August data from August HIP Enrollment Summary.

[16] Data from HIP Annual Reports 2008-2010. HIP Dashboards December 31, 2011 and December 31, 2012.

When found eligible, HIP members are able to select Anthem, MDwise or MHS as their plan, or they are placed into ESP if they identify that they have a high risk condition. Over the first three years of the program (2008 to 2010) between 68% and 70% of members have enrolled in Anthem, and 30% to 32% have enrolled in MDwise. With the changes to the ESP assignment process the percentage of HIP members enrolled in ESP increased from 1% to 3% between 2009 and 2010. This rate has held steady and in December of 2011 3.4% of HIP members were enrolled in ESP. The third demonstration year (2011) was the first year of the HIP program that had a third managed care option for members to choose from. At the end of 2011 approximately 5% of HIP members had selected the MHS and by the end of 2012 this had increased to 9%. In 2012, Anthem maintained 62% of HIP enrollment, the percent of members enrolled in MDwise dropped to 25% and the percent enrolled in ESP increased from 3% to 4%.



Over the course of the HIP program, member distribution by gender has been steady, though one gender has been predominant. At the end of the most current demonstration year (2012) 68% of enrollees are female and 32% of enrollees are male. Geographically, HIP members are distributed throughout the state, with higher concentrations in Indiana's population centers and overall enrollment reflects the population density of the state.[17] Similarly, member distribution by race has, over the course of the program, closely aligned with the distribution of working age uninsured adults under 200% FPL in Indiana.[18] Over the course of the HIP program, the percentage of enrollees who identified as white averaged around 83% and the members who identified as black averaged 10% with Hispanic, Native American and others making up the remainder. Age distribution has also been relatively steady throughout the course of the program. To date, member age distribution has consistently skewed

[17] HIP Year 3 Annual Report, Pg. 29-30.

[18] HIP Year 1 Annual Report, pg. 20.

towards more aged individuals with those under 30 representing the smallest proportion of HIP members.

Table 2: Percentage Member distribution by age

Age	2008	2009	2010	2011	2012
<30	19.3%	20%	15%	12.9%	12.0%
30-39	21.4%	25%	29%	29.9%	29.2%
40-49	26.6%	27%	28%	30.0%	30.0%
50+	32.9%	28%	28%	27.3%	28.8%

*Data from HIP Annual Reports 2008 – 2010 and HIP December 2011/December 2012 dashboards.

3.6 Benefit Limit

HIP includes an annual limit of $300,000 in benefits and a lifetime benefit maximum of $1,000,000. Over the course of the program few members have reached or come close to reaching these limits. The HIP program monitors members to ensure that members are able to be transferred to another program if they are close to reaching $300,000 in annual limits or $1,000,000 in lifetime limits. This monitoring is to ensure that members are not denied needed services. If a member does reach, or come close to reaching these limits, an attempt is made at determining eligibility for traditional Medicaid. All members who have come within $100,000 of, or reached, the $300,000 annual benefit limit were transferred to ESP, Medicaid or other programs. The number of members that met these criteria in each demonstration year are displayed below. No members have met the lifetime $1,000,000 limit.

Table 3: HIP Members at Benefit Limit

Year	Members at $200,000	Members at $300,000	Members at $1,000,000	Total
2008	1		0	**1**
2009	17	2	0	**19**
2010	1	0	0	**1**
2011	3	0	0	**3**
2012	0	0	0	**0**
Total	**22**	**2**	0	**24**

3.7 POWER Account Contributions

The POWER account, a unique feature of the HIP program, requires members to make upfront contributions to their health care costs. Based on FPL and caretaker status, contributions range from 2% to 5% of enrollee income and can be reduced by payments from an enrollee's employer or from a not-for-profit organization. Over the course of HIP, there have been a percentage of individuals who do not contribute to their POWER accounts due to the way income is counted and offset during eligibility

determination. For these members accounts are 100% state funded. The State did not intend for there to be any members who did not contribute to their POWER account, nor was this part of the original waiver negotiations. For 2008, approximately 35% of HIP enrollees did not contribute to their POWER account. Over the course of the program this percentage has been decreased and stabilized. For example, non-contributors represented in 21% of HIP enrollees in December 2010, 20.1% in December 2011, 20.6% in December 2012. This waiver renewal request includes modifications to the POWER account contributions to address the approximately 20% of members who do not contribute.

3.8 Disenrollments

Enrollees can disenroll from HIP at any time or be terminated from HIP for failing to pay a POWER account contribution, for failing to complete the redetermination process, or if it is found that the individual no longer meets eligibility requirements. Between 2008 and 2010 a total of 35,323 members left HIP. It was most common for enrollees to leave during the redetermination period approximately 12 months after being enrolled; 57% or 20,015 enrollees left the program within a month of the redetermination period. Of the remaining disenrollments, 6,199 (1,835 in 2008 and 2009 and 4,364 in 2010) members were disenrolled because they failed to pay a POWER account contribution. This represents 8% of HIP members ever enrolled in the program between 2008 and 2010. In 2011, only 1,843 of disenrollments were due to not making a subsequent POWER account payment. The remaining disenrollments from HIP would include pregnant women who are transferred to traditional Medicaid for the duration of their pregnancy (and then may reenter HIP afterwards) or member who become eligible for Medicaid disability as well as members who pass away or move out of State.[19]

Section 4: Summary of Quality Reports

As required under the STCs, the State has conducted an evaluation of the HIP program and has developed annual reports on the program. Mathematica Policy Research and Milliman have been contracted with to independently evaluate the quality of the HIP program. The 2010 annual report was submitted in June 2011 and discussed in detail the results of Mathematica's monitoring activities. The program shows noteworthy variations in care seeking behavior between contributors and non-contributors and caretakers and non-caretakers. While all of these groups respond to HIP incentives they have different ways of seeking care which the program continually investigates. A summary of these analyses are included in this waiver renewal application. The State continues to perform annual EQR reports.

Improves Access To Care:

- The HIP program appears to be meeting its goal to improve access to care for low-income Hoosiers enrolled in the plan. HIP provider networks are adequate. If there are any shortages with particular types of specialty (such as neurosurgeons), plans allow access to out-of-network providers. Data from Mathematica's 2010 survey of HIP members indicate that access to care improves after enrollment. Members are more likely to receive

[19] Data from DMA Data Request #8790, ran October 18, 2012.

preventive care and get prescription medications and report fewer unmet health care needs. In addition, the proportion of members reporting the ER as their usual source of care declines dramatically after enrollment in HIP. Mathematica surveyed the use of care in the last six months of new and established HIP members. The table below shows the difference in care utilization between new enrollees and established enrollees. Established enrollees use more primary and preventive services, prescription drugs, are less likely to use the ER and less likely to report the ER as their main source of care.

Table 4: Care Utilization between new enrollees and established enrollees[20]

Care Utilized	New Enrollees	Established Enrollees
Primary Care	60%	90%
Preventive Care	28%	69%
Prescription drugs	54%	80%
ER	38%	32%
ER as main source of care	30%	9.2%

- Mathematica continues to document that 90 percent of HIP members have a physician visit within 12 months of enrolling.
- A Milliman analysis of HIP enrollee service utilization for the first 18 months of the program compared HIP enrollees to comparable Medicaid and commercial populations. HIP incentives for members to seek preventive care have demonstrated success. Individuals enrolled in HIP had higher preventive care visits than Indiana's HoosierHealthWise (HHW) Medicaid population. The HIP Caretaker population had 445.4 well-care visits per 1,000 enrollees, and the non-caretaker population had 281.8 well-care visits per 1,000 enrollees compared to HHW adults 195.3 visits per 1,000 enrollees. This analysis indicates that HIP Caretakers seek preventive care more frequently than comparable commercial populations and non-caretakers seek preventive care at rates similar to comparable commercial populations.

Table 5: Preventive Care Utilization (January 2008-June 2009)

Population	Well Care Visit (utilization rate per 1,000)
HHW- Adults	195.2
HIP-Caretakers	445.4
HIP- Non-Caretakers	281.8
Commercial (Adult only) (1)	354.8
Commercial (Adult only) (2)	306.2
Ohio Medicaid Adults	352.7

(1) Age / Gender adjusted to HIP – Caretaker population
(2) Age / Gender adjusted to HIP – Non Caretaker population

[20] Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3 (2010), pg. 38. Submitted June, 2011.

- The State monitors member access on a monthly basis including evaluating health plans primary and specialty care networks. Member access is examined on distance from primary and specialty care providers, access to hospital care, and appointment wait times. Mathematica reports that with enrollment in HIP utilization of health care services increased and unmet need declined.

Increases Knowledge of Health Care Spending:

- Data from Mathematica's 2010 survey of HIP members indicate that most survey respondents were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it. Approximately 60% reported knowing the balance of their POWER account and 45% reported checking their account at least monthly, important first steps of cost conscious consumers.[21]
- A 2009 Product Acceptance Research (PAR) telephone survey of HIP members found that six in ten respondents now think differently about how or where they get health care since enrolling in HIP and that one-third have asked the cost of a medical procedure or service before receiving treatment.

POWER Account/Consumer Directed Plan Does not Discourage Participants from Seeking Needed Care:

- Mathematica's analysis of utilization shows that members are accessing services and that the POWER account contributions do not discourage participants from seeking needed healthcare. As individuals remain enrolled in HIP, they move away from seeking routine care in the ER and begin seeking care in physicians' offices. Over 12 months of enrollment, on average HIP enrollees show a 14.8% decline in non-emergent ER use and a 25% increase in physician office visits. No evidence was found suggesting that HIPs consumer based structure discourages enrollees from seeking needed care. Additionally, a Mathematica survey of HIP members found that approximately 70% of enrollees indicated that the monthly contribution was just the right amount and something they could afford. Another 7% thought they could afford a monthly contribution that was a little higher than the current amount. In contrast, approximately 8% thought the monthly contribution was far too high.
- At its conception, the HIP program intended to have all members contribute to their POWER account; however, due to the way income is calculated and the lack of a program requirement for a minimum contribution, since 2010 approximately 20% of enrollees have not been required to contribute to their POWER account. This has led to an opportunity to analyze possible differences in care seeking behavior between contributors and non-contributors. Contributors have lower rates of ER use from the beginning of their

[21] Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3.

enrollment in HIP. Over 12 months of continuous enrollment 35% of contributors visit the ER with 24% visiting the ER at least once for a non-emergent visit. Non-contributors visit the ER more frequently; 57% visited the ER and 34% of non-contributors enrolled for 12 months continuously had a non-emergency ER visit. Non-contributors also experience fewer gains in than contributors in physician office visits; for contributors physician office visits increase by 26% over 12 months of enrollment and for non-contributors it increases by 22%.[22]

Table 6: HIP Members Service Utilization

Over 12 Months of continuous enrollment:	Contributors	Non-Contributors
Any ER Visit	35%	53%
Any Non-Emergency ER Visit	25%	34%
Increase in Physician Office Use	26%	22%

Whether contributing to a POWER account has a direct effect on care seeking behavior remains under investigation. Non-contributors have unique care seeking behavior and are overall more likely to visit an ER than contributors. This may be influenced by their contributor status, however, for all enrollees, the HIP program works over the course of enrollment to decrease non-emergency ER use and increase physician office use.[23]

- A Milliman analysis of the first year of Anthem's experience with HIP showed that after adjusting for morbidity differences non-contributors have higher expenditures than contributors. The non-contributor caretaker population had 3.5% increased expenditures over the contributor caretaker population and the non-contributor non-caretaker population had expenditures 13% higher than the non-contributor non-caretaker population.[24]

Currently, HIP is a fully functioning program achieving several of its goals including: improving access to care for low-income Hoosiers; promoting preventive care among most HIP members; providing quality of care; achieving high levels of member satisfaction; and maintaining the program's fiscal soundness. Enrollment patterns continue to indicate that upon entry to the HIP program, most members remained enrolled for a full year or more. Steady enrollment provides opportunities for HIP and the health plans to (1) give members guidance on how to use health care services appropriately and (2) reap the benefits of initiatives that promote the use of preventive care, disease management programs, and case management services. It also means that members have an opportunity to benefit from responding to program incentives.

[22] Matematica Data Preview, December 2nd, 2010.

[23] Data in this paragraph: Mathematica data supplement for the HIP Year 3 Annual Report: December 2, 2010.

[24] Milliman report to HIP Taskforce: August 7th, 2009.

4.1 Progress on Program Goals

Goal 1: Reducing the number of uninsured low-income Hoosiers

- HIP seeks to reduce the number of uninsured low-income Hoosiers. HIP has been providing an important safety net for its members who would have been uninsured otherwise. Given the expected limited revenue from the State cigarette tax, HIP was not intended to cover all Hoosiers below 200% of FPL. As of December 31, 2012, HIP has served 105,135 Hoosiers.
- Although the overall uninsured rate among low-income working-age Hoosiers did not change between 2008 and 2009, data suggest that uninsured rates among caretakers declined by 4%. At the same time, Medicaid coverage rates among low-income caretakers increased by 7.1%. Those with income below 150% of the FPL experienced declines in their uninsured rates. For example, working-age adults with income between 101% and 150% of FPL saw their uninsured rate decline by 2.6% between 2008 and 2009 while their Medicaid coverage rate increased by 4.3%. The increase in Medicaid coverage rates among low-income adults who are typically not eligible for Medicaid unless they have a disability, suggest that during the economic downturn, Medicaid, including the HIP program, was moderating any increase in uninsured rates.
- Between 2009 and 2011 Indiana's uninsurance rate for individual between 18 and 65 is estimated to have declined slightly. In 2009 aggregate data indicates approximately 734,000 adults were uninsured (18.8% of population over 18 and under 65) and in 2011 this estimate had decreased to 671,000 (17.3% of the population over 18 and under 65). No direct analysis has been conducted to indicate HIP directly impacted this decline in the number of uninsured working age adults in Indiana, however, HIP coverage may have been a factor in this decrease.[25]

Goal 2: Reduce barriers and improve statewide access to health care services for low-income Hoosiers

- Plans report that all HIP members, in all health plans, have access to a primary medical provider (PMP) within 30 miles of their homes.
- All plans continue to work on their specialty networks; deficiencies are few, and plan administrators think problems with certain specialties are due to general medical shortage areas, or inadequate numbers of providers for the population as a whole in some regions of Indiana.
- A 2010 Mathematica survey of HIP members suggests that access to care improves after enrollment into HIP. Using respondents who had only enrolled in HIP in the previous month and their access to care while uninsured as the control against which the success of HIP is judged, the survey data indicate that HIP members are:
    - More likely to have a PMP and more likely to use a doctor's office or clinic as their usual source of care rather than the ER,
    - More likely to receive preventive care, acute care, specialty care, and prescription medications, and
    - Less likely to have an unmet need for care.
- All plans are required to submit access reporting annually along with a geo-access map of provider locations. If a plan does not have the necessary access as outlined in the scope of work,

[25] Data based on 2012 Census Bureau release.

the plan must submit the reporting on a monthly basis and outline efforts to increase access. At this time, all plans are meeting the access requirements.

Goal 3: Promote value-based decisions making and personal health responsibility

- HIP uses several financial incentives to encourage members to become thoughtful health care purchasers and active participants in maintaining or improving their health. These incentives begin upon enrollment, when most HIP members are required to contribute to the cost of their care by making monthly payments to their POWER accounts. Findings to date suggest that:
    - As of the end of 2012, nearly four of every five HIP members made a contribution to their POWER account.
    - Utilization differences have been noted between contributors and non-contributors. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members. The non-contributing population in general suffers from higher morbidity, however, the POWER account contributions and the influence of consumerism cannot be ruled out as factors contributing to this vast difference in utilization.[26]
    - Survey data collected by Mathematica in 2010 suggest that the majority of respondents knew key features of the program. For example, 81% of established HIP members were aware of their POWER account, 71% of these believed that they had been given adequate information about the accounts, and 95% knew their monthly contribution amount.
    - Over the first two years of the HIP program only 3% of enrollees were disenrolled for failing to pay their POWER account contribution. The disenrollment rate increased over the third year with 4,364 individuals being disenrolled in year three. This was more than twice the number of individuals disenrolled for failure to pay a POWER account contribution for the first two years of the program. The number of individuals disenrolled for failure to pay a POWER account contribution in 2011 was more consistent with the first two years of the program with 1,843 individuals not making a subsequent POWER account contribution. Over the first four years of the program 9% of total enrollees have been disenrolled for failure to pay a POWER Account contribution. Over half of total disenrollments occurred in 2010 which appears to be an outlier. It is expected with further years' data on disenrollments due to failure to pay a POWER account contribution that the percentage for the life of the program will decline.
    - HIP member eligibility is redetermined annually. Enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85% of HIP enrollees returned redetermination packets on time. This percentage has increased through the life of the program and the most recent year of the demonstration, 2012, at least 92.33% of enrollees submitted their redetermination packet on time.

[26] Data from Mathematica Data Enclosure, December 2010.

Goal 4: Promote primary prevention

- A large proportion of HIP members obtain primary care services. Given that most HIP members stay enrolled in the program, and only some are cycling on and off, HIP and its health plans should see benefits in promoting the receipt of appropriate preventive care. HIP encourages the use of preventive services by providing first dollar coverage for preventive services. Preventive services up to $500 are not subject to the deductible and members do not have to draw on their POWER account funds. HIP also ties POWER account rollovers, and reductions in future monthly contributions, to the completion of required preventive care.
    - Roughly 90% of HIP members who started eligibility periods in 2008 and 2009 and stayed continuously enrolled for 12 or more months had a physician office visit of any type.[27]
    - Service records for the seven different preventive services the Office of Medicaid Policy and Planning (OMPP) required for full rollovers consistently indicate that the majority of HIP members received some type of preventive care during their first year of enrollment.
    - Analysis of the first 18 months of HIP shows that members have greater rates of preventive care use than the HHW Medicaid population. Over this period, for every 1,000 enrollees HIP had 445.4 caretaker preventive visits and 281.8 non caretaker preventive visits while the HHW population had 195.2 preventive visits per 1,000 enrollees. HIP preventive use in caretakers is greater than similar commercially insured populations and the use in non-caretakers is comparable to a similar commercially insured population.[28]
    - Considering only services obtained in the first six months after enrollment in the HIP program, encounter claims records indicate that 2009 members obtained preventive care more quickly. For example, within the first six months of enrollment, 41% of young (ages 19-34) female 2008 members had received at least one recommended preventive service. Among 2009 members, 46% of females met this criterion within the first six months of enrollment.[29]
    - To promote preventive care, the health plans are pursuing a number of different strategies, including member mailings, newsletters, telephone outreach, and support. The ESP administrator implemented a new care coordination program in 2010.

Goal 5: Prevent chronic disease progression with secondary prevention

- By lowering cost and access barriers to care and activating members to be more engaged patients, HIP aims to slow disease progression among members with chronic conditions. Analyses to date indicate that:

[27] HIP Year 3 Annual Report, (June 2, 2011).

[28] Milliman Data, Presentation to Governor March 23, 2010.

[29] HIP DY 3 (2011) Annual Report.

- Chronic disease is prevalent among members. More than a quarter of those enrolled from January 2008 through June 2010 have been diagnosed with pulmonary, skeletal and connective tissue, cardiovascular, metabolic, or skin diseases. In addition, more than 40% of members have been diagnosed with or treated for psychiatric conditions, including non-chronic depression.
- Non-caretakers were more likely than caretakers to be diagnosed with chronic diseases and are nearly twice as likely to be diagnosed with conditions that are considered to be medium or high cost (24 versus 13 percent), which is consistent with the age differences between these two groups.
- The health plans continued to use several strategies to manage the chronic conditions of their members, including telephone support, disease management programs, and online tools.
- Analysis conducted by Milliman shows that while HIP enrollees experience significant chronic disease burden, that during enrollment in the program use of prescription medication increases and inpatient, outpatient, emergency room usage, and physician services decline. This suggests that HIP members are managing their chronic conditions with prescription medication and, as a result, need fewer direct health services.

Goal 6: Provide appropriate and quality-based health care services

- A critical goal for HIP is to provide appropriate and quality-based health care services and HIP appears to be achieving this goal.
    - Overall satisfaction appears to be high among HIP members. Respondents to the CAHPS surveys administered by the health plans report high levels of satisfaction with their plans—levels that, in most cases, are comparable to or higher than national averages for Medicaid plans. For example, Anthem's plan average composite score for customer service (which includes the percent reporting they always or usually got information they needed from the plan's customer service line, and the percent reporting they always or usually were treated with respect by customer service staff) was 89.3 %, a statistically significant difference from the 2011 national average score of 79.7 % putting them in 90th percentile. Likewise, 83.6 % of MDwise members were always or usually satisfied with their experiences with receiving care and getting appointments in a reasonable time, also a statistically significant difference from the 2011 national average. 2011 was the first year data was added from MHS CAHPS results and it is positive to note that, similarly, 83.7 percent of MHS members were always or usually satisfied with receiving care and getting appointments in a reasonable time ("getting care quickly").
    - Mathematica's 2010 survey of HIP members also indicates high levels of satisfaction with the HIP program overall. Approximately 87% of respondents who were new to

HIP and 97% or respondents who were established were "Very Satisfied" or "Somewhat Satisfied" with the HIP Program.

- Data from the State's Intranet Quorum, the State's issue management system, are consistent with the CAHPS data and do not indicate that members have any serious concerns about the performance of the plans.

Goal 7: Assure State fiscal responsibility and efficient management of the program

- The HIP program continues to meet its budget neutrality requirements. According to the estimates by the program's actuary, Milliman Inc., the State had a waiver margin of $94 million during the first year of the demonstration,[30] which exceeded the projected waiver margin of roughly $28 million for that year. The HIP achieved this margin despite enrolling more non-caretakers than had been projected. The large margin resulted from the savings achieved for the HHW populations (3 to 6 percent over the projected per member per month (PMPM) rates for this group) and the substantial savings achieved for the HIP caretakers (16 percent over the projected per member per month rate).
- The enabling state legislation requires HIP to be a fiscally sound program. As of the end of calendar year 2012, the HIP program appeared to be achieving this goal. State documentation indicates that:
  - The HIP program continued to meet its budget neutrality goals as of the end of 2012.
  - Contract negotiations with the health plans address the costs of care.
  - Analysis of the funding mechanisms for HIP finds that state funding was adequate during the program's first five years. Cigarette tax revenues, while declining, were sufficient to meet the program's needs, and the proportion of HIP members contributing to their POWER accounts remains steady.

4.2 Future Goals of the Demonstration

If the program continues, the State will continue to pursue the goals identified above and will conduct further study of these areas. Additional study and time to collect data will help the State understand the long term impact of HIP. The State intends to continue to investigate the effects of consumer directed health plan design on enrollee care seeking behavior. The State expects that changes to HIP due to modifications to IC 12-15-44.2 that allow plans to make payments to POWER accounts as disease management incentives may positively impact enrollee behavior. The impact of these contributions on enrollee care seeking behavior will be studied. The State will also study the impact of the required minimum contribution on enrollment and care seeking behavior.

4.3 Health Plan Performance-External Quality Review

In 2010, Burns & Associates, Inc. conducted an external quality review (EQR) of Anthem and MDwise for calendar year 2010. The EQR assessed the performance of the health plans in six areas: (1) cultural competency initiatives, (2) program integrity, (3) accessibility and availability of providers, (4) retrospective authorizations, claim denials, and claim disputes, (5) validation of performance measures,

[30] The waiver margin is the difference between expenditures and the spending limit established in the STCs.

and (6) validation of performance improvement projects. Plans were assessed independently, and assessments were made for both HIP and HHW programs. OMPP continues to contract with an EQR assessor and results are made available to CMS.

Overall, the EQR found that both plans were fully compliant in the areas assessed. The following outlines some important findings and recommendations:

- Both Anthem and MDwise have undertaken numerous initiatives related to cultural competency, but the EQR recommended that the plans utilize the U.S. Department of Health and Human Service's Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) standards as a tool to ensure that their cultural competency work plans follow these recommended guidelines. In addition, the EQR recommended that Anthem make more materials available in Spanish, and that both plans better use the race and ethnicity data from OMPP in conjunction with claims data to better target health disparities within the HIP population. Anthem has submitted and OMPP has approved additional materials in a Spanish format. All plans have reported that they maintain race and ethnicity data in their respective systems. The Culturally and Linguistically Appropriate Services (CLAS) standards were implemented with re-bid in 2011. The plans have done internal gap analysis to identify and meet the standards.
- Both plans are following credentialing and recredentialing policies and procedures for HIP, and in early 2010, both plans placed a renewed emphasis on investigating fraud and abuse cases. For example, the plans expanded staff assigned to investigations, and increased the number of investigations they conducted in 2010. They also recommended that since the investigations team is newer at MDwise, that MDwise adopt an ongoing training schedule, similar to what Anthem uses.
- Few clinical issues were disputed in either retroactive authorization or claims disputes, except in ER cases where the 'prudent layperson' rule was cited (and in those cases, the EQR agreed that these denials were made appropriately in cases where they had adequate records to assess this). In addition, most claims denials occurred for administrative reasons, usually because the service was out-of-network or the provider submitted the claim dispute too late (both HIP plans use a "60 day" rule for filing a claim dispute, which complies with the State's administrative rule [405 IAC 1-1.6]). Although the EQR recognized that 'out-of-network' and untimely filing of claims are legitimate reasons for a denial, they suggested that more education, aimed at members about the differences between in- and out-of-network services, and at providers on the timeframe required to dispute claims, is needed. The use of in-network services and the importance of a PMP have been further highlighted throughout the updated member handbooks. Provider education on claims submission is offered by the plans as well as the State's fiscal agent.
- Reviews of the validity of the processes used to report four performance measures in HIP found the data used by the plans appeared to be valid, but the EQR did suggest that improvements could be made. For example, the data reported in Anthem's and MDwise's

provider claims dispute reports appeared to be valid, but there were different interpretations between the plans as to what information to provide in the report, so that the results cannot be compared between the plans. OMPP updated the reporting manual for 2011 to further identify and define the needed information for this report. OMPP has been working with the plans to ensure that the information is comparable across plans.

The EQR report does not suggest the plans have any systematic issues related to their performance. The recommendations and suggestions made to the plans recognized a level of competency at the plans, citing several items as best practices. For example, Anthem's newly hired staff to investigate fraud and abuse was cited as having a very strong process for handling investigations, and among the HHW and HIP plans, "…best illustrated to the EQR how the results from Special Investigations Unit investigations often get fed back as improved processes on the front end to other parts of the organization to prevent fraud and abuse." MDwise was cited for its cultural competency programs, including that MDwise "releases all of its materials in English and Spanish, avoiding the need for Spanish-speaking members to have to specifically request these materials."

After the release of the EQR report in November 2010, the plans took steps to address EQR recommendations regarding provider education. For example, MDwise is providing additional provider education through one-on-one contact and through newsletters. In 2011, Anthem began distribution of a new member handbook for the HIP and HHW programs, and the plan also began sending letters to any provider treating an Anthem member who is in the plan's case management or disease management program, to try to improve care coordination.

Section 5: Requested Program Changes

During the 2011 legislative session, the Indiana legislature passed IC 12-15-44.2 and made changes to HIP; additionally, further guidance and analysis supports minor changes to HIP. The State seeks waiver authority to implement both legislative changes and the changes stemming from recently released guidance. These changes include:

- Requirement for HIP enrollees to make a minimum contribution of $160 annually, or $13.33 per month. This requirement is limited by income and no enrollee will pay more than 5% of income towards health costs.
- Ability for health plans to contribute towards members' POWER accounts as incentives for healthy behavior.
- Reduction of the HIP eligibility level to 138% FPL to reduce overlap between HIP an Exchange coverage
- Elimination of the requirement to be uninsured for 6 months or to not have access to employer sponsor insurance as eligibility factors.
- Modification of co-payments for non-emergency use of the emergency room to align with January 2012 Notice of Proposed Rulemaking (NPRM).
- Modification to the State's budget neutrality agreement based on its experience to date and proposed changes.

5.1 Requested Change: Minimum Contribution

During the original negotiations with the CMS, it was presumed that all individuals would be making a POWER Account contribution, and the amount of the sliding scale was adjusted to ensure that no individual exceeded the 5% of income limit on cost-sharing, including consideration of CHIP premiums. However, after applying the CMS rules of how income is counted, there were individuals who did not make contributions. On average over the life of the program, HIP has approximately 20% of participants that are not making contributions to their POWER account and this number has been as high as 35%. During the 2011 session, the Indiana General Assembly passed legislation to correct this issue and instituted a minimum contribution of $160 (IC 12-15-44.2-11).

The sliding scale to calculate member contributions will still be in place, and the legislation limits the minimum contribution to the sliding scale that is in the original waiver. Members will be required to contribute their minimum monthly contribution ($13.33 a month) until they meet the sliding scale limit. The State will also consider all contributions being made by the household including CHIP and Medicare premiums in calculation of the 5% contribution limit. This assures that no individual exceeds the CMS limit of 5% cost-sharing. Once the sliding scale percentage limit is met the State will fund the account. Please see Section 8 on cost sharing for detailed plans to ensure these individuals do not exceed the applicable percentage of income limiting their contributions. For HIP members that do not currently pay a POWER account contribution, the State has developed a plan to transition them to contributing enrollees. Please see the transition plan under Section 9 for more detail.

5.2 Requested Change: Managed Care Entity Contributions

While the 2013 waiver extension notice granted Indiana's request to allow not-for-profit entities to make contributions into the POWER account, CMS did not indicate if MCEs can make contributions to the POWER account. The 2011 legislation at IC 12-15-44.2 also allows for the HIP contracted MCEs to contribute to the individual's POWER account. Contributions must be linked to a health related incentive, such as completion of a risk assessment or participation in a smoking cessation program. Again, the original drafters had intended to allow the MCEs to provide health related incentives to individuals through the POWER account. However, the legislation did not specify this and therefore all health related incentives have been paid or given directly to individuals outside the POWER account. Allowing MCEs to pay health incentives to the POWER account aligns with HIP's philosophy and should strengthen the incentive for individuals to invest in health promotion efforts. The new legislation indicates that MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's $1,100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.

5.3 Requested Change: FPL Adjustment

The Supreme Court of the United States declared that the expansion of the Medicaid population authorized under the PPACA is optional and up to the discretion of the State. At present, the State of Indiana has not determined if it will participate in this expansion. Indiana's 2011 HIP legislation reduces the HIP eligibility threshold to 138% FPL (133% with 5% income disregard), for enrollees that are not

eligible for Medicaid under another category (such as aged, blind, or disabled populations, pregnant women, children, etc.). This will assure there is limited overlap with the tax credits available through the Exchanges. Please see the eligibility information in Section 6 for more details on Medicaid and HIP eligibility and the transition plan in Section 9 for more details on the process for transitioning to the revised FPL limit.

To bring HIP in line with PPACA requirements, it is the State's intent to change HIP eligibility from 200% FPL to 138% FPL (133% with 5% income disregard) effective January 1, 2014. Eligibility would be maintained to 200% through 2013 and the State would begin the transition to 138% FPL in October 2013 at the time of Exchange open enrollment. If the state elects to expand Medicaid, HIP coverage will begin in January 2014 for non-caretaker adults who enroll during the open enrollment period (see Section 9 for the Transition Plan).

A reduction of the eligibility threshold to 138% of FPL is not expected to adversely impact a large percentage of HIP members. While data is not presently available for the precise number of HIP enrollees over 138% FPL, in December 2012, 10% (3,966) of HIP members were over 150% FPL and 8% (3,165) were between 125% and 150% FPL; the vast majority of HIP members (82%) are under 125% FPL and will not be affected by this change. For those members who will be transferred from HIP to subsidized commercial products on the Exchange, the State has developed a plan to aid HIP enrollees in this transition. Please see the transition plan at Section 9 for more details.

5.4 Requested Change: Benefits

The new legislation provides the Secretary of the Indiana Family and Social Services Administration the ability to adjust the HIP benefits to be in line with the new benchmark benefits. At this time, we are not requesting any changes to the current HIP benefit package. Based on the State Medicaid Director Letter issued November 20, 2012 addressing the Essential Health Benefits (EHB) Benchmark requirements for the Medicaid program, a preliminary analysis of HIP benefits and the EHB requirements was completed and limited variance was found. The State requests additional guidance around the expectations for the Alternative Benefit Plan analysis for Secretary Approved coverage. In addition, while the State is not currently requesting changes to the benefit plan, we would like to add pregnancy coverage to HIP. It is understood that while initially excluded from HIP by the enabling legislation, that maternity coverage is a requirement under plans covered by EHB. The addition of pregnancy coverage would gain administrative and program efficiencies by eliminating the process that requires members to transfer from HIP to pregnancy Medicaid for the duration of their pregnancy. These topics are discussed in more detail in section 7.

5.5 Requested Change: Cost-sharing

The NPRM covering Medicaid premiums and cost-sharing published in the Federal Register January 22nd 2013 modified the amount that can be charged for non-emergency use of the ER. Encouraging appropriate ER use is a key goal of the HIP program and HIP has included co-payments for non-emergency use of the ER since inception. Previous co-payments for non-emergency use of the ER

ranged from $3 to $25 depending on caretaker status and income. To align with the proposed rule, we request approval to change HIP co-payments for non-emergency use of the ER to $8 per visit or the CMS updated rate for years after 2015. The flat rate for all enrollees is expected to bring some simplification to program administration. As indicated by the proposed rule, this co-payment will apply to all covered individuals in HIP. As is specified by HIP enabling legislation, POWER Account contributions may not fund HIP co-payments for non-emergency use of the ER.

5.6 Requested Change: Eligibility Factors

To align with PPACA requirements, the 2011 legislation that updated HIP removed the requirements that to be eligible for HIP an individual has to have been uninsured for at least 6 months and not have access to employer sponsored insurance. Per the modified legislation, these are only eligibility factors for HIP through December 31st, 2013 and we request they be removed as an eligibility factor for HIP starting in 2014.

5.7 Requested Change: Budget Neutrality

Since HIP extended coverage to non-caretakers that are not currently eligible for Medicaid, the original HIP demonstration project included a budget neutrality agreement. The State based its budget neutrality agreement on diverted Disproportionate Share Hospital (DSH) funding, savings projects, and limited expenditure growth in the HHW population. As a result, CMS agreed to allow the State to cover 34,000 non-caretakers. This number was adjusted in 2009 to 36,500 and remains at this level through the current demonstration year. The 2013 budget neutrality agreement does not divert DSH and the savings projects are complete.

The HIP program continues to meet and exceed its budget neutrality requirements and therefore the State requests an adjustment to reflect the current scenario, and also to adjust for the PPACA changes. Due to the savings projects the State implemented, the waiver margin has far exceeded projections and requires adjustment. In addition, since non-caretakers are now eligible for Medicaid, the State requests bringing non-caretakers to the "without waiver" side of the equation, starting in 2014. We have prepared the budget neutrality documents to reflect 2014-2016 and these are included as an attachment.

As of January 1, 2014 all individuals under 138% FPL will become eligible for Medicaid, regardless of caretaker status, therefore the State requests that non-caretaker adults be treated similar to the caretaker adults, in the budget neutrality agreement starting in 2014 and not subject to an enrollment cap. As discussed in section 6.6 HIP legislation limits program enrollment to what can be supported by available funding.

Indiana proposes to continue the agreed trend from the original demonstration project for the HHW population through the waiver demonstration period. Please see the financing attachment for the specifics on the requested changes to the budget neutrality agreement.

Section 6: Eligibility

For the current demonstration extension period from January 1, 2013 to December 1, 2013 HIP eligibility will continue to extend to 200% FPL. Individuals will be HIP eligible if they are between 19 and 64 years

of age, have been uninsured for at least 6 months, are not otherwise eligible for Medicaid, and do not have access to employer sponsored insurance. In order to prepare for the PPACA, as directed by IC 12-15-44.2, the State proposes to begin to make eligibility changes to coordinate with the PPACA provisions starting on 10/1/2013. From 1/1/2013 to 9/30/2013 income for new applicants and redeterminations will be calculated using the current income calculation process. The final eligibility regulation states that it is considering allowing states to convert to modified adjusted gross income (MAGI) prior to 2014 using an 1115 demonstration. The HIP demonstration would like to take advantage of this opportunity. To coordinate with Exchange open enrollment periods, income for new HIP applicants will be calculated as of 10/1/2013 based on MAGI. This waiver requests changing eligibility to 138% FPL as of January 1, 2014; however, from 10/1/2013 to 12/31/2013 HIP applicants will continue to be eligible to 200% FPL based on MAGI. The regulation also prevents individuals from being excluded for coverage due to a MAGI calculation prior to March 31, 2014. Indiana believes that implementing MAGI for HIP consistent with the open enrollment period increases operational effectiveness; however, to maintain consistency with the proposed regulation, Indiana will allow individuals found ineligible, to also be reviewed based on the current eligibility process between October 1, 2013 and March 31, 2014.

The State will prepare to transition HIP members that are above 138% FPL to the Exchange (federal or state). Indiana proposes to schedule a special redetermination period for all HIP enrollees whose current eligibility information indicates they are over 138% FPL in January, 2014. At this point all enrollees will have their eligibility redetermined based on MAGI; please see the transition plan in Section 9 for more details.

6.1 Populations Ineligible for HIP

Individuals eligible for services under traditional Medicaid are described below in Table 7. None of these populations will participate in HIP and therefore, none of these populations will have POWER accounts.

Table 7: Current Medicaid Populations Ineligible for HIP

1. Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance
2. Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)
3. Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)
4. Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)
5. Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)
6. Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)
7. Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)
8. Mandatory categorically needy low-income parents eligible under 1931 of the Act
9. Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):
10. Individuals qualifying for Medicaid on the basis of blindness
11. Individuals qualifying for Medicaid on the basis of disability
12. Institutionalized individuals assessed a patient contribution towards the cost of care 1902 (f)

13. Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)
14. Children receiving foster care or adoption assistance under title IV-E of the Act
15. Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)
16. Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)

6.2 Populations Eligible for HIP

The populations described below in Table 8 are the current HIP eligible populations that will be covered through October 2013. Due to PPACA implementation and changes to IC 12-15-44.2 eligibility for HIP will change between 2013 and 2014, if the waiver is approved. Table 9 notes the revised eligibility that will be effective 1/1/2014. Details about how these eligibility changes will be implemented can be found in the transition plan.

Table 8: HIP Program Eligibility January 1, 2013 to December 31, 2013.

Description	**FPL and/or other qualifying criteria** ***MAGI income calculation begins 10/1/2013 consistent with Exchange open enrollment period**	**Demonstration Eligibility Group**
Demonstration Eligible Groups **January 1, 2013 to December 31, 2013**		
Custodial parents and caretaker relatives currently excluded from the Medicaid State plan who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income up to the AFDC income limit for the particular family size as indicated in the State Plan with resources in excess of $1,000	Parents and Caretakers
Custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid	Income above the AFDC income limit for the particular family size as indicated in the State Plan and up to and including 200% FPL; no resource limit.	Parents and Caretakers

benefits or Medicare.		
Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers, who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	0% FPL through 200% FPL; no resource limit. At no point in time may the number of individuals exceed 36,500.	Non-caretaker Adults

October 1, 2013 the State will begin to determine eligibility based on MAGI. Non-caretakers who meet the criteria for Medicaid eligibility under the PPACA, but who cannot enroll directly in HIP due to the non-caretaker enrollment cap will be enrolled in HIP coverage effective January 1, 2014. The requirements that an individual have been uninsured for at least six months and not have access to employer sponsored insurance are removed from the HIP eligibility criteria effective January 1, 2014. Individuals who apply between October 1, 2013 and December 31st, 2013 and are otherwise eligible but ineligible due to these criteria will be granted coverage effective January 1, 2014.

Table 9: Healthy Indiana Plan (HIP) Program Eligibility January 1, 2014 to December 31, 2015

Description	**FPL and/or other qualifying criteria**	**Demonstration Eligibility Group(s)**	**Consistent with below group(s) prior to January 1, 2014**
Demonstration Eligible Groups January 1, 2014 to December 31, 2015			
Adults ages 18 to 64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income under 138% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% disregard, payment of POWER account contribution, no resource limit	Adults (As described in the final rule at 42 CFR 435.119 “the adult group”, parents/caretakers below 23% FPL will not be in HIP.)	Parents and Caretakers, Non-Caretaker Adults

6.3 Eligibility Exclusions

The current HIP program excludes the following individuals from HIP coverage.

- Those eligible for comprehensive Medicaid under the State Plan (see Table 9) with the exception of the forthcoming family planning option.
- Those eligible for Medicare.
- Pregnant woman for the purpose of pregnancy related services.
- Those otherwise eligible for Medical assistance.
- Those with income in excess of 200% FPL.
- Those who have had insurance in the past six months.
- Those have access to an employer-sponsored health plan.
- Those who fail to pay a POWER account contribution within 60 days, not inclusive of the first POWER account contribution, are excluded from HIP eligibility for 12 months if they fail to pay.

As described in sections 5.3 and 5.6 this waiver renewal request includes changes to the eligibility criteria for the HIP program. If these requests are granted, beginning in January 2014 individuals over 138% FPL based on MAGI will no longer be eligible for HIP and individuals who have been insured in the last 12 months or have access to an employer-sponsored health plan will not be excluded from HIP eligibility. Assuming these requested changes are granted, the below individuals will be excluded from HIP coverage starting January 2014.

- Those eligible for another Medicaid category under the State Plan (see Table 9), with the exception of the forthcoming family planning option.
- Those eligible for Medicare.
- Those otherwise eligible for medical assistance.
- Those with MAGI in excess of 138% FPL (133% with 5% disregard).
- They are excluded from HIP eligibility for 12 months if they fail to pay a POWER account contribution within 60 days; not inclusive of the first POWER account contribution.

Currently the HIP enabling legislation excludes pregnant woman for the purposes of pregnancy related services as these individuals are transferred to pregnancy Medicaid to receive these services. As discussed in sections 5.4 and 7, we have outstanding questions about maternity coverage in HIP and seek guidance on this topic. If pregnancy coverage is added to HIP then pregnant woman will no longer be excluded from the program beginning in 2014. However, if HIP remains without a maternity benefit as is currently the case, then the current process will remain and those in need of pregnancy related services will be transferred to pregnancy Medicaid.

To align with the Exchange enrollment period, starting October 1, 2013, the State will begin to use MAGI income calculation to determine HIP eligibility. Between October 1, 2013 and December 31, 2013 HIP applicants disqualified from HIP coverage due to access to employer-sponsored health plans or insurance in the last six months but otherwise eligible for HIP will be enrolled in HIP coverage effective January 1, 2014. During this same period, non-caretakers who cannot be immediately enrolled due to the enrollment cap will be granted coverage effective January 1, 2014 and placed on the waitlist.

The State submitted a family planning option State Plan Amendment (SPA) per the direction of the Indiana General Assembly and this SPA has been approved. Enrollment in family planning only services

category (MA E) began January 1, 2013. HIP eligibility indicates that a person cannot be eligible for other Medicaid programs. The family planning aid category eligibility criteria will overlap with the HIP eligibility criteria. Therefore, we wish to clarify in the waiver that individuals eligible for the family planning aid category are not ineligible for HIP. The family planning option does not provide comprehensive medical services rather coverage is limited to family planning services and products only. While an applicant may be eligible for both programs, an individual can only participate in one of the programs; HIP or the family planning SPA. Persons participating in HIP have access to comprehensive medical services including family planning, as long as they make their POWER account contributions. An individual may participate in the family planning optional category, and receive family planning services without any contribution. The purpose of this policy is to ensure that barriers are not erected for individuals to elect the coverage that is right for them, whether that be family planning or HIP.

6.4 The Exchange and HIP

At this time, Indiana is not pursuing a state-based Exchange, however, has not yet determined if it will pursue a partnership Exchange (HIX), or will fully cede Exchange functions to the federal government. Regardless of Exchange model, FSSA will work to coordinate with the Exchange to ensure that HIP eligibles have a seamless enrollment experience.

6.5 Special Redetermination Period

Based on the Indiana Code, the income standards for HIP change January 1, 2014. HIP will initiate a special redetermination period starting January 1, 2014 for all individuals whose current eligibility information shows they may have income in excess of 138% FPL based on MAGI. Individuals who are determined ineligible for HIP based on income will be assisted with screening for eligibility for premium tax credits and in pursuing coverage options through the Exchange. Please see the transition plan in Section 9 for more details.

6.6 Enrollment Limit

The original HIP legislation was explicit that HIP is not an entitlement program, and that the State may not enroll new participants if revenues from the cigarette tax cannot support additional clients. The waiver contemplated achieving this by means of (1) eliminating the disregard for HIP caretakers and (ii) placing an enrollment cap on HIP adults. (See approved STC 21 and 22). If Indiana elects to expand Medicaid and HIP is the coverage vehicle, then for this waiver demonstration period through 2014 through 2016, it is expected that there will be sufficient funding that a cap is not needed. However, considering other scenarios, dependent on funding and consistent with the enabling legislation, the HIP program will be monitored to ensure that revenue is sufficient to support enrollment levels. Going forward the State will request enrollment limits as necessary to ensure that HIP costs do not exceed available revenue.

Section 7: Benefits

The benefits provided by HIP are described below.

HIP offers the following coverage:

1) A basic commercial benefits package once annual medical costs exceed $1,100.
2) A POWER account valued at $1,100 per adult to pay for initial medical costs. The POWER accounts provide incentives for participants to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER accounts depending on their income level and the State funds the remainder of the account.
3) $500 in "first dollar" preventive benefits; these benefits are at no cost to HIP members and will not deplete their POWER account.

Table 10: HIP Benefits

Benefit	**Limits/Inclusions (as applicable)**
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service
Skilled Nursing Facilities	Subject to a 60-day maximum
Outpatient Facility	
Surgery	
Emergency Room	Co-payment for services determined to be non-emergency : $6 for adults 100% FPL to 133% FPL, $3 for adults up to 100% FPL
Urgent Care	
Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Pharmacy and Blood	Generic preference, brands allowed when no generic is available
Professional Services	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient ER Visits	
Office Visits/Consults	
Preventive Services	At least $500 annual first dollar coverage

Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness
Ancillary Services	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available
Home Health	Excludes long term care.
Hospice	
Emergency Transportation	
Durable Medical Equipment/Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).
Lead Screening Services	Under 21 Years of Age
Hearing Aids	
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Subject to the HIP benefit coverage limits
Disease Management Services	

The benefits package for HIP is not benchmark equivalent, as it does not cover maternity care or non-emergency transportation and includes a $300,000 annual and $1,000,000 lifetime limit. Milliman, Inc. conducted an analysis comparing HIP to a benchmark benefit plan included as an attachment. Currently, HIP has waivers for the requirement to offer these services and seeks continuation of these waivers.

The new legislation provides the Secretary of FSSA the ability to adjust the HIP benefits to be in line with the new benchmark benefit requirements. Based on the November 20, 2012 Medicaid Director Letter and the Essential Health Benefit requirements the state has conducted a preliminary analysis of the HIP benefits in comparison to Indiana's default Essential Health Benefit benchmark plan.

The State Medicaid Director Letter issued November 20, 2012 advises Medicaid Agencies on the process for meeting the Essential Health Benefit Benchmark requirements through the Medicaid Benchmark.

This process indicates that Secretary-approved coverage needs a completed analysis of the benefits offered in comparison to a base benchmark plan. As noted, in August 2010, Milliman certified that the current HIP benefits do not meet the benchmark equivalent standard based on the PPACA coverage requirements As such, HIP is not a benchmark-equivalent plan and would be considered Secretary approved coverage.

Preliminary analysis has been completed comparing HIP benefits to Indiana's commercial default base-benchmark plan though Indiana has not completed an actuarial analysis of these benefits at this point, as the requirements for such an analysis are still unknown. However, the preliminary benefit comparison between the commercial EHB default HIOS submission and HIP indicates that, overall, the HIP benefits align with the benefits of the default commercial EHB benchmark. However, there are some areas of variation around which the State will need additional guidance.

Specifically additional guidance is needed around maternity coverage. The HIP enabling legislation specifically excludes pregnant woman from eligibility for pregnancy related services. Currently, when an individual in HIP becomes pregnant they are transferred out of HIP to Medicaid for the duration of their pregnancy and afterwards they can reenroll in HIP. However, the 2011 legislation gave the Secretary of FSSA the ability to add benefits as required to meet PPACA requirements. Indiana expects that some administrative efficiencies will be gained by adding pregnancy coverage to HIP instead of transferring pregnant woman out of HIP for pregnancy coverage. The PPACA lists maternity coverage and newborn care as a required essential benefits in §1302(b)(1)(D). However, when defining those eligible for Medicaid's benchmark coverage plan in §2001(a)(1)(C) the provision excludes those who are pregnant as they are already eligible for Pregnancy Medicaid. Indiana seeks additional guidance from CMS on this issue and requests clarification on what programs can enroll pregnant women under 138% FPL with the 5% income disregard.

Section 8: Cost-Sharing

Currently, HIP utilizes two forms of cost sharing. First, it requires copayments for non-emergency ER visits. Second it requires individuals to contribute to their POWER accounts. Collectively, the State assures that individuals do not make contributions that exceed 5% of their income. Contributions to POWER accounts are used to pay for health care services received before the deductible is met. POWER account contributions are made on a sliding fee scale basis and are detailed below. Currently caretakers, consistent with the CMS standard, do not pay more than 5% of their annual income in combined cost sharing (POWER account contributions and ER copays). Caretakers make required POWER account contributions on a sliding scale up to only 4.5% of their income, leaving room for any potential ER copays. Non-caretakers in the current HIP program have up to 5% for their required POWER account contribution and pay a flat $25 for all non-emergency ER visits.

Independent legal analysis of the HIP POWER account contributions—included as an attachment--indicates that POWER account contributions should not be classified as premiums. Section 1916A of the Social Security Act defines "premium" to include "any enrollment fee or similar charge." The enrollee contribution to the POWER account is not an "enrollment fee;" rather, it is a contribution towards the $1,100 amount in the account. In that way, it is closer to either a deductible or co-insurance (although,

unlike those two, it does not relate to a particular service at the time it is paid). Unlike a premium payment, HIP enrollees continue to own their required contributions and in the event of disenrollment from the program any of their remaining contributions are returned to them.

Per CMS rules for HIP caretakers, the total aggregate amount of (1) POWER account contributions, (2) HIP copayments, (3) Medicaid cost sharing requirements, and (4) CHIP cost sharing requirements may not exceed 5% of family income. If a member approaches the cost sharing limit, the health plan verifies the member's cost-sharing documentation, and then notifies the HIP program manager that the member has reached the 5% maximum contribution amount and the date it occurred. The member is not required to pay any further POWER account contributions or ER co-payments for the rest of the 12-month benefit period. OMPP is working on an automated process that will monitor and verify members spending on POWER account contributions, CHIP premiums and copayments and ensure that these payments do not exceed 5% of income.

8.1 Copayments

Overall, copayments will change to accommodate the new status of non-caretakers as indicated by the PPACA. Since HIP eligibility will align with the PPACA Medicaid expansion group in 2014, those over 138% FPL will no longer be eligible for HIP as of January 1, 2014. Copayments for non-emergency use of the ER are displayed below. After 2014 and PPACA implementation, the higher copayment for HIP Adults will be eliminated, as at that time they become a categorically eligible Medicaid group. As indicated in section 5.5 and starting in 2014, HIP intends to align with the proposed co-payments for non-emergency use of the emergency room at 42 CFR 447 and the copayment will be $8 or the updated co-payment amount for non-emergency use of the ER as specified by the proposed regulation.

Table 11: Waiver Extension Current Demonstration Year 6 Cost Sharing January 1, 2013 to December 31, 2013 (current HIP waiver)

Population	Non-Emergency ER Use Co-Payment Amount	Power Account Contribution
HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL	$3 per visit	Not more than 2% of income
HIP Caretakers Above 100 % through 150% FPL	$6 per visit	3% to 4% of income
HIP Caretakers Above 150 % through 200% FPL	Lower of 20 percent of the cost of the services provided during the visit, or $25	Not more than 4.5% of income
HIP Adults	$25 per visit	2% to 5% of income based on FPL

Table 12: Waiver Extension Demonstration Year 7 to 9 Cost Sharing January 1, 2014 to December 31, 2016

Population	Non-Emergency ER Use Co-Payment Amount	Power Account Contribution
Adults With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL based on MAGI	$8 per visit or updated copayment amount per CMS guidance	Not more than 2% of income
Adults with incomes >100% FPL through 125% FPL based on MAGI	$8 per visit or updated copayment amount per CMS guidance	Not more than 3% of income
Adults with incomes >125% FPL through 138% FPL based on MAGI	$8 per visit or updated copayment amount per CMS guidance	Not more than 4% of income

8.2 POWER Account

The POWER account is an HSA styled account that HIP enrollees use to cover HIP's $1,100 deductible and is the centerpiece of the HIP plan. In the majority of cases both enrollees and the State contribute to the POWER account. Since the beginning of the HIP program between 20% and 35% of POWER accounts have been fully funded by the State as the individuals were not required to pay a POWER Account contribution. The cornerstone of the HIP program is to promote personal responsibility and consumerism in the healthcare system and including non-contributors in the program is contrary to the program's goals; these individuals have no "skin in the game" or incentive to be cost conscious consumers.

The HIP program emphasizes personal responsibility, and the vast majority (92%) of POWER account contributors pays their POWER account contributions on time. HIP enrollees who do not pay any contributions are not expected to have the same degree of personal responsibility as they cannot be disenrolled for failure to pay a contribution. Potentially related to the paying of contributions, these non-contributors have higher non-emergency use of the ER (66.8 visits per 1000 enrollees vs. 34.7 visits per 1,000 enrollees for contributors). The utilization differences between contributors and non-contributors suggest that paying a contribution may impact responsible care seeking behavior.

As discussed previously, HIP has not experienced problems with affordability, and a Mathematica survey of HIP members found of established members that 69% of contributors consider the amount of their POWER account contribution to be 'just right', while 7% indicate they could pay an even greater contribution; 17% indicate the contribution is a little too much and only 5% of HIP established enrollees felt their contribution was far too much.[31] Under HIP, employers are also able to contribute up to 50% of an individual's required contribution and non-profits are able to contribute up to 75% of an individual's required contribution.

During the 2010 legislative session, the Indiana legislature modified IC 12-15-44.2. These modifications include language that requires members to contribute a minimum amount to their POWER account to

[31] Results from Mathematic 2010 Survey of HIP Members.

ensure that all individuals are making contributions and have the appropriate consumer incentives, or "skin in the game." The minimum amount required is an annual contribution of $160 but not more than 2% of income for an enrollee under 100% FPL, 3% of income for and enrollee from 100% to 125% FPL and 4% of income for an enrollee 125% to 150% FPL. The percentage limits in the enabling legislation may prevent very low income adults from making the full minimum contribution. In contrast to the Affordable Care Act's Premium Tax Credits, contributions to POWER Accounts, other Medicaid cost sharing, and copays are limited to a total percentage of income. While an individual covered on a tax credit would be subject to only the maximum out-of-pocket cost-sharing limit, individuals covered by HIP have all cost sharing limited to no more than 5% of income, dependent on FPL. Table 13 indicates the proposed POWER account contributions. Individuals will contribute the required minimum monthly contribution until they meet their income limit and then required contributions for those individuals will be suspended.

Table 13: POWER Account Contributions 2014 to 2016

Annual Household Income	Minimum POWER Account Contribution	Maximum POWER Account Contribution	Estimated maximum annual/monthly contribution Individual	Estimated maximum annual /monthly contribution Family of 4
All enrollees less than 25% FPL	$160 annually but not more than 2% of annual income	Not more than 2% of income	$54.46/ $13.33	$111.76/ $13.33
All enrollees between 25% and 50% FPL	$160 annually but not more than 2% of income	Not more than 2% of income	$108.90/ $13.33	$223.50/ $18.63
All enrollees between 50% and 75% FPL	$160 annually	Not more than 2% of income	$163.36/ $13.61	$335.26/ $27.94
All enrollees between 75% and 100% percent FPL	$160 annually	Not more than 2% of income	$217.80/ $18.15	$447.00/ $37.25
All enrollees above 100 through 125 percent FPL	$160 annually	Not more than 3% of income.	$408.39/ $34.03	$838.14/ $69.85
All enrollees above 125 percent FPL	$160 annually	Not more than 4% of income.	$579.35/ $48.28	$1,100/ $91.67

HIP's current demonstration year allows not-for-profit entities to make up to 75% of an individual's required contribution and employers have always been able to make up to 50% of an individual's required contribution. Individuals who receive sponsorship from not-for-profits or employers may pay

less than the displayed minimum contributions. Enrollees pay their contributions in equal monthly installments, and are also permitted to pay the entire sum up front. HIP members that struggle to pay the required minimum contribution will be able to seek employer or non-profit support.

The original authorizing language for HIP indicated that only the State, employers, and individuals can make contributions to the POWER account. IC 12-15-44.2 allows not-for-profit organizations to assist with contributions and contribute up to 75% of the enrollee's contribution requirement. This request was approved in the 2013 HIP waiver. Not-for-profits are not allowed to contribute 100% of the member's POWER account contribution because a central tenant of the HIP program is for all individuals to contribute to their care. HIP currently allows employers to contribute up to 50% of an individual's contribution to the POWER accounts and extending this option to not-for-profit organizations fits with the program's goals to provide affordable, consumer directed coverage. An employer's contribution limit will remain at 50% of the enrollee's contribution requirement.

For those members who do not currently contribute, and who will be required to start contributing on their first redetermination period after January 1, 2014 the State has developed a transition plan described in detail in the next section (section 9).

The State will continue to ensure that the POWER account is fully funded from the beginning of individual enrollment and will continue to contribute to ensure that the deductible can be met if expenses occur at the beginning of the enrollment period. Health plans are required to collect the POWER account contribution from individuals, and individuals will not receive HIP coverage until the first day of the coverage month after the first contribution is received. This is the current policy and the State requests no changes to this.

The required minimum contribution of $160 represents 5% of income for an individual making $3200 a year, or 29% FPL. IC 12-15-44.2-11 that contains the language instituting the minimum contribution also contains language that limits maximum contributions. The language from IC 12-15-44.2-11 concerning the minimum contribution requirements and limiting maximum amounts is excerpted below.

> *At least one hundred sixty dollars ($160) per year and not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:*
>
> - *Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level.*
> - *Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level.*
> - *Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level.*

- *Five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level.*

To track entire family spending on Medicaid services, the State is implementing a process to automatically monitor member expenditures and ensure that POWER account contributions, CHIP premium payments, and copayments never exceed 5% of a member's income in line with CMS guidelines. This implementation is consistent with the requirements outlined in the January 2013 NPRM on cost-sharing requirements.

Section 9: HIP 1115 Waiver Renewal Transition Plan

OMPP has developed a transition plan for two scenarios, based upon CMS' approval or denial of the HIP 1115 demonstration waiver extension. Should the State's waiver request be denied, the State will begin dismantling the HIP program in July 2013 as described in Plan B. If the waiver is approved, the State will proceed with Plan A.

Plan A: 1115 receives approval for three year extension (2014, 2015 & 2016)

Once the State receives approval from CMS, FSSA will publish a press release and notify all legislators of the waiver approval and the plan for the program going forward.

The changes addressed in this transition plan, which directly affect HIP members, are (1) the reduction of the upper eligibility threshold from 200% FPL to 138% effective January 1, 2014, and (2) the requirement of a minimum member POWER account contribution of $160 annually (subject to a 5% income limit) or approximately $13/month.. "Plan A" addresses the continuation of the waiver and is subdivided to address several populations affected by changes to the 1115 waiver from its original demonstration to the proposed structure in this waiver extension. "Plan A" populations are:

(1) Per IC 12-15-44.2 and the Affordable Care Act, current HIP members between 138% FPL and 200% FPL who will no longer be eligible for HIP coverage in 2014, but will be eligible for an Exchange product.

(2) HIP currently operates a waitlist for approximately 40,000 non-caretaker adults. It is assumed that the majority of these individuals may either be eligible for enrollment in HIP, if the State elects to expand Medicaid coverage, or an Exchange product and tax subsidy in 2014.

(3) HIP members who currently make no contributions to their HIP POWER accounts ("zero contributors") due to current income counting requirements, but will be required to contribute $160 annually beginning at the start of their renewal period in 2014, as required by State statute, and if approved by CMS.

(4) HIP members under 138% FPL who will maintain HIP eligibility, but may be affected by the $160 annual contribution to the POWER account. These members are currently contributing less than $160 annually.

Trainings will take place with the MCEs (Anthem, MDwise, MHS and ESP administrators) as well as provider and other community based organizations. The goal of the trainings is to prepare key stakeholders for the upcoming changes so they may begin planning, as necessary, how to best assist HIP members in the transition. Information will also be available on FSSA's HIP website (www.HIP.in.gov).

(1) Current HIP members between 138% FPL and 200% FPL

A waiver extension for three years will result in program changes at the end of demonstration year six for current members between 138% FPL and 200% FPL, provided that the request to reduce HIP eligibility to 138% FPL is granted. Individuals with MAGI income between above 100% FPL will become eligible for Exchange subsidies beginning January 1, 2014 and per Indiana code those over 138% FPL based on MAGI would no longer be eligible for HIP, pending CMS approval of the eligibility threshold. The March 2012 release of the final rule for 42 CFR Parts 431, 433, 435, and 457 *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010* relating to modified adjusted gross income (MAGI), state the following:

"Proposed §435.603(a)(1) and (2) set forth the basis and scope of this section. At proposed §435.603(a)(3), we implement 1902(e)(14)(D)(v) of the Act, as added by section 2002(a) of the Affordable Care Act, which specifies that, in determining ongoing eligibility of individuals enrolled in the Medicaid program as of January 1, 2014, the financial methodologies based on MAGI shall not be applied until the next regularly-scheduled redetermination of eligibility after December 31, 2013 or March 31,2014, if such individual otherwise would lose eligibility as a result of the shift to MAGI-based methodologies before such date."

As of January 1, 2014 individuals between 138% and 200% FPL will no longer be eligible for HIP as a result of the HIP change in the eligibility threshold effective on that day, not as a result of a change to MAGI calculation. The following is proposed for individuals between 138% and 200% FPL, who are enrolled in HIP prior to 2014. In keeping with the philosophy that those under 138% FPL will be enrolled in Medicaid, if the State elects to expand Medicaid, and over 138% FPL will be enrolled in a Qualified Health Plan with tax subsidies, the transition plan modifies the redetermination period, such that individuals enroll in a QHP early in 2014. This plan reduces duplication of services offered through multiple programs. The plan for transitioning individuals between 138% and 200% FPL is as follows:

- Upon waiver extension approval from CMS and no later than July 1, 2013, FSSA will commence putting together a change order for the Indiana Client Eligibility System (ICES) and the claims/MMIS system to reflect the eligibility threshold change, effective January 1, 2014.

- For individuals enrolled in HIP above 138% FPL under current eligibility standards, a special redetermination period will commence January 1, 2014. Letters will be sent to individuals identified as between 138% and 200% FPL, by October 2013, notifying them of the special redetermination date and of their potential eligibility for coverage through the Exchange. This process aligns the redetermination dates with Exchange enrollment periods.
- October 1, 2013 - A letter regarding changes to the HIP program will be mailed no later than October 2013 to HIP members between 138% and 200% FPL notifying the member that based on the income information the State has, the member may lose HIP eligibility if, at redetermination, their income remains over 138% FPL. The letter will note that a second letter will be mailed by January 1, 2014 advising the member to complete the redetermination, how to complete the redetermination, and if found ineligible for HIP but eligible for a tax subsidy, how to enroll in an Exchange product.
- October 1, 2013 - A letter will be sent to all enrollment centers informing them of the changes to the program for individuals between 138% FPL and 200% FPL and how to assist an individual in enrolling in an Exchange product
- The State will develop online training materials for stakeholders to assure there is widespread communication about the changes.
- January 1, 2014 – Redetermination letters will be mailed to individuals above 138% FPL based on MAGI. Individuals will have 60 days to complete their redetermination packet. If found eligible for HIP, they will remain enrolled in HIP. If income remains above 138% FPL based on MAGI at redetermination, these individuals will be referred for tax subsidy screening.
    - Phone numbers will be provided in the letters for each MCE as well as the Exchange, such that individuals could begin selecting products once they receive their eligibility determination from the State or Exchange. Information on other available Medicaid products and where to obtain and submit an application will be included in the letter.
    - The State will track the progress of the population and may also consider outbound phone calls to members that have not responded.
    - For individuals who are found eligible for a tax subsidy, the State will close out the POWER account. .
- March 31, 2014 – Termination letters will be sent to HIP members who did not complete their redetermination. These letters will include information on how to enroll in an Exchange product or reapply for HIP. Members will be eligible to appeal this determination according to FSSA appeals processes if they feel the decision was made in error.

(2) Individuals currently on the HIP waitlist

The State will take steps necessary to inform individuals on the HIP waitlist that they will be eligible for HIP, if the State elects to expand Medicaid, or an Exchange product in January 2014.

- October 2013 – At the time of the Exchange open enrollment, ICES will issue letters to individuals on the HIP waitlist, in batches, stating that they may be eligible for HIP and that there will no longer be a waitlist for the program. Individuals will need to reapply for the program in order to prove they are still eligible and will need to file this application no later than 45 days from the date of the letter. A phone number will be provided on the letter for individuals to call should they have questions or need assistance. The enrollment broker would be leveraged to assist with any returned letters and subsequent outreach to clients, as noted in the prior section.
    - Case numbers of individuals who are sent application invitation letters will be flagged in ICES so DFR will know who to process as waitlist applicants.
    - In processing eligibility, access to employer sponsored insurance and insurance within the last 6 months will only disqualify individuals through December 31st, 2013. Individuals with these disqualifications but otherwise eligible for HIP will be granted coverage effective January 1, 2014.
    - If application is received by DFR by the due date (within 45 days), but without all required documentation to determine eligibility, they will complete the same follow up to obtain verification.
    - All applicants over 138% FPL will be screened for tax subsidy eligibility, in coordination with the Exchange's open enrollment period. From October 1, 2013 to December 31, 2013 HIP will maintain eligibility levels to 200% FPL; however, tax subsidy screening for the eligible portion of the HIP population will promote streamlined transitions to Exchange coverage for this population.
- Coverage would not begin until January 1, 2014 for non-caretakers from the waitlist who are determined eligible for HIP.
- If the State elects not to expand Medicaid, individuals on the HIP waitlist will be notified of their Exchange coverage options through the process described above.

(3) Current members who currently make no contributions to HIP POWER accounts ("zero contributors")

- As soon as waiver approval is received from CMS, FSSA will run a data query to identify all HIP members who currently do not make POWER account contributions. A letter will be sent to these HIP members informing them that they will be required to make POWER account contributions beginning on their first redetermination after January 1, 2014 and that employers may contribute up to 50% and not-for-profit groups may contribute up to 75% of their monthly payment (no more than 100% of a member's contribution may be contributed on behalf of the member to the account in any one benefit period). Individual required contributions will not be phased in until their redetermination period.
- The State will also work with not-for-profit entities and community based organizations to inform them of this recent change.
- The State will meet with the MCEs and other stakeholders to walk staff through the program changes. MCEs will be asked to help coordinate the effort and to be prepared to work with their members to make the transition.

- Changes will be made to FSSA's eligibility (ICES) and claims management systems (MMIS). It will be particularly important to ensure that no one has a zero contribution and that the default contribution is never zero, but is at least $160 annually or approximately $13/month subject to the income limits present in statute.
- After January 1, 2014 at each individual's appointed redetermination period, the individual will be given information regarding their new POWER account and how to appeal the decision.
- The appeal process for HIP will not change with waiver renewal. Individuals will be required to file an appeal in writing. Once an appeal is received and processed an appeals hearing will be scheduled with Hearings and Appeals.

(4) *Those under 138% FPL who maintain eligibility may be affected by the changes to the POWER account rules, as their POWER account contribution may increase.*
The same process as described in item (3) will be followed, with the difference being that the letters will be tailored to those who may have a change in the amount of their POWER account contribution due to the minimum contribution. The letters will continue to describe the opportunity for not-for-profit and employer participation.

Plan B: 1115 does not receive approval for 3 year extension & the program is dismantled

Should the State not receive approval to continue the 1115 waiver, the State will begin dismantling the HIP program by July 2013. The State will require at least six months of preparation to ensure the transition runs smoothly. The last day of the program will be December 31, 2013. Appropriate steps will be taken to ensure that all members are aware of the closure of the program and of other options that might be available to them.

- Upon denial from CMS:
  - FSSA will publish a press release and notify all State and Federal Indiana legislators of the denial and the impending termination of the program. The FSSA HIP website (www.HIP.in.gov) will be updated to indicate the future of the program.
  - Letters will be sent to all HIP members informing them that, due to waiver denial, the program will end on December 31, 2013. The letters will note that HIP members may continue to receive coverage for healthcare services through December 31, 2013, should they continue to meet eligibility requirements. The letters will also contain information on other products that could be available to these members upon the closure of the program, such as other Medicaid categories, the PCIP, exchange coverage, and commercial insurance.
  - Letters will also go out to individuals on the HIP waitlist notifying them of the closure of the program and the subsequent discontinuance of the waitlist. The waitlist will immediately close and no additional individuals will be placed on the waitlist.
  - The above process will be repeated, to ensure that communication is received.

  - The State will begin negotiations with the three MCEs to amend their contracts to terminate the HIP portion of their combined HHW and HIP contracts.
  - The State will develop a plan to utilize the remaining dollars in the HIP fund.
  - Letters and bulletins will be sent to Medicaid providers, enrollment centers, community based organizations and other key stakeholders of the change informing them of the end of the program.
  - FSSA will commence making necessary changes to its eligibility and claims management systems to ensure that members are terminated and that no capitation payments are made to health plans.
- July 2013 - FSSA will stop processing new HIP applications. Any application in process will be denied due to termination of program. Redeterminations will cease, and individuals will be left in the HIP program until the end of the year. DFR staff will be trained to inform clients that HIP is no longer an option, and applications will be removed from the website and local offices.
- December 2013 – Letters will go out to each HIP member informing them that their coverage was terminated; there will be no appeal rights associated with this termination as the program will have ended. The letters will detail the options that will be available beginning in 2014 via the Exchange, other Medicaid programs, and the commercial market.

Section 10: Evaluation reports

Mathematica developed an evaluation plan for HIP during the HIP initial demonstration period. HIP is meeting its program goals and providing quality care to clients. During the extension period, Indiana expects to continue to make some modification to the evaluation design and to focus on new areas of study. Evaluation reports address HIP's progress on program goals in addition to the evaluation questions present in the Special Terms and Conditions (STCs).

Evaluation reports will include evaluation on the below HIP goals:

1. Reduce the number of uninsured low income Hoosiers.
2. Reduce barriers and improve statewide access to health care services for low income Hoosiers.
3. Promote value-based decision making and personal health responsibility.
4. Promote primary prevention.
5. Prevent chronic disease progression with secondary prevention.
6. Provide appropriate quality-based health care services.
7. Assure State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the below STC evaluation questions:

1. How many HIP participants reach their $300,000 annual benefit limit each year? How do these individuals meet their health care needs during the period of exhaustion of their benefit and the beginning of the next coverage term?
2. How many HIP participants reach their $1,000,000 lifetime benefit maximum? How do they go about meeting their health care needs after their HIP benefits are exhausted?

3. What are the consequences of limiting participants' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCO?
4. How many enrollees are reassigned from HIP MCOs each year to ESP? How many are reassigned from ESP to a HIP MCO?
5. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
6. What are the consequences of requiring HIP participants with family income less than 150 percent of the FPL to pay monthly premiums? How many of these participants fail to make their first POWER Account contribution? How many of these participants are disenrolled for failure to pay their premiums?
7. To what extent has HIP impacted the uninsurance rate in Indiana?
8. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
9. How many enrollees exhaust their POWER Account each year? How many enrollees are able to roll-over a sufficient POWER Account balance to reduce their subsequent year's required contribution by at least half? How many enrollees are able to achieve a $0 contribution by this means?

During the waiver extension period the State also intends to investigate if the minimum contribution requirement effectively changes the care seeking behavior on current non-contributors and encourages more cost conscious consumption of health care services.

Section 11: Public Comment

FSSA held public hearings for this three-year 1115 waiver extension according the requirements under 42 CFR 431. The notice that announced two public hearings is included in Appendix A of this renewal request, and it was published in the *Indiana Register* on February 20,' 2013. The full notice was also posted on the agency's website at the web address of the 1115 waiver program's homepage: HIP.in.gov. Electronic copies of all documents related to the three year waiver extension were also available on the website. In addition, OMPP published the notice in the Indiana Health Care Provider (ICHP) Bulletin, which was sent electronically to all IHCP providers. In accordance with the notice, public hearings were conducted March 20 and 22, 2013. The hearing held on March 20 was made available to the public via a telephone conference line and a live, free webcast. The hearing held on March 22 was also made available to the public via webcast. The notice provided the option for any individual, regardless of whether he/she attended the public hearing, to submit written feedback to the State by email or by USPS mail.

Additionally, as part of the normal legislative process, hearings were held in the Senate Health and Provider Services Committee and the House Public Health Committee regarding pending legislation.[32] Legislators provided and received testimony regarding the Healthy Indiana Plan waiver and Medicaid expansion at the February 13, 2013 committee meetings, and agency staff attended these committee hearings. Many of the individuals who testified during the legislative hearings on February 13 offered public comment during the aforementioned hearings on March 20 and 22.

[32] Testimony taken in regards to Senate Bill 551 and House Bill 1591.

11.1 Summary of Public Comments

The hearings on March 20 and March 22, 2013 were held as scheduled and publicized, at the Indiana Government Center Conference facilities and the Indiana State House. Eleven individuals testified on March 20, and nine individuals testified on March 22. A court reporter transcribed both hearings. Comments were also received in writing by e-mail and regular mail. A total of twenty individuals testified at the HIP hearings, and fifty-nine written comments were received. The below summary combines the comments offered at the public hearings and via mail or email.

Over seventy-nine comments were received by the agency. The majority of comments were generally supportive of the HIP program and/or expanding Medicaid. In particular, Anthem and MDwise, two of the managed care entities (MCEs) serving HIP members, provided testimony that noted HIP enrollees are more likely to engage in care programs and follow through on personal health accountability. These entities supported HIP's consumer oriented program. They further indicated HIP's member responsibility provisions positively contribute to member health outcomes and provide evidence that a contribution model delivers cost-effective outcomes regardless of contribution level. The MCEs noted, in comparison to other Medicaid enrollees, HIP members have lower emergency room use and lower inpatient admissions, are more likely to schedule and attend physician office visits, are more engaged in their coverage options through call centers and web portals, have high rates of completion of recommended preventive services, and are more likely to comply with prescription medication regimens.

Supportive comments were received with respect to using the HIP program to expand Medicaid. Individuals commented HIP is a landmark program. One individual noted HIP "has been a central component in the State's effort to provide quality, cost-effective health coverage for low income adults." Further testimony stated that HIP offers a foundation for the expansion of Medicaid in Indiana, and could be leveraged in an expansion to decrease costs and increase quality of care. Support was voiced for HIP's personal responsibility mechanisms, including cost-sharing mechanisms and incentives for obtaining preventive care services, and including these mechanisms in a potential Medicaid expansion.

Members of the business community, including the Indiana Chamber of Commerce and the Indiana Manufacturers Association, and provider community, including the Indiana Hospital Association, the Indiana State Medical Association, and numerous hospitals, expressed support for HIP as an innovative, consumer-directed, private market approach to expanding Medicaid. They stated any Medicaid expansion in Indiana must be aware of long term fiscal implications, and support was lent to HIP as a fiscally sound approach to a coverage expansion. Some of these organizations gave praise to HIP's ability to decrease use of the emergency room and increase use of preventive care, to improve consumer behavior including seeking the cost of procedure prior to receiving them, and to yield high enrollee satisfaction. They supported HIP's higher provider reimbursement rates and the associated decrease in cost-shifting to the private market. Additionally, some testimony noted POWER account contributions are vital to the success of the HIP program and need to remain intact to ensure the program is successful moving forward.

Comments consistently urged CMS to promptly respond to the HIP waiver request to ensure continued coverage in 2014 and to further the discussion in the state around a potential Medicaid expansion. Some individuals commented only with regards to support of a Medicaid expansion and did not address support or lack of support for the HIP program.

Five comments received in writing or through testimony expressed concern around certain features of the program including: the lifetime and annual maximums, the twelve month lock-out period for failure to pay a premium, the requirement to not have access to employer sponsored insurance, the non-caretaker waitlist, and non-provided benefits including chiropractic, dental, and vision services. These comments also addressed concerns about multiple types of coverage within a family unit and HIP integration with the federally-facilitated exchange. One commenter noted support for expansion of HIP's cost-sharing requirements to include copayments beyond the copayment for non-emergency use of the ER. Those who commented regarding the aforementioned recommendations to the program indicated support for the renewal of HIP and the use of HIP for a potential Medicaid expansion provided their concerns are addressed.

Eight comments received in writing or through testimony expressed concern about the HIP waiver renewal or use of HIP as the foundation of a Medicaid expansion. These individuals cited concerns related to: potential cost-sharing for pregnant women in HIP, co-payments for non-emergency use of the ER, the requirement for individuals to make POWER Account contributions, churn between HIP and other Medicaid programs and the Exchange, the relative cost of HIP compared to other Medicaid programs, and the ability to scale the program to cover the entire Medicaid expansion population.

11.2 State Response to Comments

The State appreciates all comments received. In its discussions with CMS and through the potential development of the Special Terms and Conditions, the State will consider these comments in context of the outcome data around HIP's design features and the impact on the goals of the program.

The waiver request as written addresses many comments received, and the State has made no changes to this application, at this time, in response to the public comment period and public hearings. The content of this application is identical to the advanced copy application submitted to CMS on February 13, 2013.

Section 12: Types of waivers being requested

The State is requesting the below waivers.

<u>Title XIX Waivers</u>

Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements

or on the absence of managed care arrangements. Individuals enrolled in the Hoosier Healthwise program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in Hoosier Healthwise.

1. **Freedom of Choice** **Section 1902(a)(23)**

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

2. **Reasonable Promptness** **Section 1902(a)(3)/Section 1902(a)(8)** To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

3. **Methods of Administration: Transportation** **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana not to assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

4. **Eligibility Section** **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

5. **Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" in the proposed rule at 435.119, benefits that differ from the benefits offered to the categorically needy group.

6. **Income and Resource Test** **Section 1902(a)(10)(C)(i)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults). Indiana will request this waiver for 2013 only. In 2014, asset tests will not be allowed under federal law.

7. **Freedom of Choice** **Section 1902(a)(23) insofar as it incorporates 42 CFR 438.52(a)**

To the extent necessary to enable Indiana to provide only one choice of plan for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are identified as having certain high-risk conditions.

8. **Retroactive Eligibility** **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

9. **Prepayment Review** **Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana not to ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

10. **Cost-Sharing** **Section 1916A**

To the extent necessary to enable Indiana to charge require POWER account contributions and copayments up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

11. **Dental and Vision Coverage for Certain HIP Caretakers and HIP Adults** **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

12. **Income Limit** **Section 1902(a)(10)(a)(I)(VIII)(i)**

To the extent necessary to enable Indiana to limit enrollment to levels that can be supported by the state's cigarette tax fund.

The current STCs grant HIP the below waivers. The State believes that these waivers are no longer necessary for the HIP program and does not request that their inclusion in the waiver renewal.

13. **Statewideness/Uniformity** **Section 1902(a)(1)**

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

14. **Disproportionate Share Hospital (DSH) Payments** **Section 1902(a)(13)(A) insofar as it incorporates Section 1923(c)(1)**

To the extent necessary to allow Indiana to divert of a portion of DSH payments made to hospitals to cover the demonstration population.

Section 13: Financing Reports

Please see attached financing report prepared by Milliman Inc.

Appendix A: 2013 Notice of Public Hearing

Notice of Public Hearing

Under 42 CFR Part 431 and the final rule under PART 431 in the February 27, 2012, issue of the Federal Register, 77 FR 11678-11700, notice is hereby given that:

(1) on March 20, 2013, at 1:30 p.m., at the Indiana Government Center South, 402 West Washington Street, Conference Center Room C, Indianapolis, Indiana; and

(2) on March 22, 2013, at 1:30 p.m., at the Indiana State House, 200 West Washington Street, Room 156B, Indianapolis, Indiana;

the Family and Social Services Administration will hold public hearings on a Medicaid 1115 waiver renewal submission to the Centers for Medicare and Medicaid Services to extend the demonstration for the Healthy Indiana Plan (HIP) for calendar years 2014-2016. The current 1115 waiver is set to expire on December 31, 2013. As a result of recent changes to Medicaid eligibility initiated by the Patient Protection and Affordable Care Act (ACA) and changes authorized by the Indiana General Assembly at IC 12-15-44.2, the waiver renewal application includes the authorized modifications to HIP, as well as requests for minimum contributions, the ability for managed care entities (MCEs) to contribute towards members' required contribution, cost-sharing changes, changes to eligibility factors, and adjustments to federal poverty level (FPL) bands.

The HIP demonstration project was approved in December 2007, and the program began on January 1, 2008. HIP currently covers nondisabled adults between the ages of 19-65 who meet the following qualifying criteria: income less than 200% FPL, no access to employer-sponsored insurance, and no health coverage within the six month period prior to application. The program includes a $1,100 deductible and creates Personal Wellness and Responsibility (POWER) accounts to fund the deductible. Individuals are required to make income driven monthly contributions to the POWER account, and the state funds the remainder of the account to ensure that the $1,100 deductible can be met. Minimal copayments of $3, $6, or $25 are charged for nonemergency use of the emergency room, per the current HIP program. In 2014, the current copayments will be replaced with a flat $8 copayment authorized by proposed federal regulations (42 CFR 447.54).

HIP is delivered via risk-based managed care and provides a basic commercial benefit package once medical costs exceed $1,100. Additionally, $500 in first dollar preventive benefits is provided at no cost to the individual. There are seven program goals in the proposed 1115 waiver application: (1) reduce the number of uninsured low-income Hoosiers, (2) reduce barriers and improve statewide access to health care services for low-income Hoosiers, (3) promote value-based decision making and personal health responsibility, (4) promote primary prevention, (5) prevent chronic disease progression with secondary prevention, (6) provide appropriate and quality-based health care services, and (7) ensure state fiscal responsibility and efficient management of the program. HIP will be evaluated based on progress towards these goals.

HIP currently covers approximately 39,000 individuals. The purpose of this 1115 waiver renewal is to continue HIP for three years to continue and to make other ACA-related changes. Changes to the program in this waiver extension, authorized in IC 12-15-44.2, include:

- A requirement for enrollees to make a minimum contribution to their POWER Account of $160 annually (but guarantees that individuals will not pay more than 5% of their income towards health costs).
- An ability for HIP-contracted MCEs to contribute to the individual's POWER account. Contributions must be linked to a health related incentive, such as completion of a risk assessment or participation in a smoking cessation program. MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's $1,100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.
- Changes HIP eligibility levels to 133% FPL (with 5% income disregard) starting on January 1, 2014. The current eligibility threshold is 200% FPL.
- Changes the requirement that to enroll in HIP an individual must have been uninsured for at least six months and not have access to employer sponsored insurance as authorized by IC 12-15-44.2.
- Changes co-payments for non-emergency use of the ER to align with proposed cost-sharing guidance.

In the first five years of the 1115 demonstration project, HIP covered 105,135 individuals. Current enrollment for the program is approximately 39,000 individuals. Based upon the financial documents prepared with the waiver, the program renewal could cover up to a total of 165,000 parents and 262,000 adults. Changes to the budget neutrality agreement have been made to reflect the ACA changes. Per the memorandum included with the waiver application "1115 Waiver Renewal-Budget Neutrality Filing", and assuming coverage for the optional Medicaid expansion population, expected expenditures are $5.1B, $5.4B, and $5.8B (state and federal) in 2014, 2015, and 2016 respectively. The expected savings, respectively, via the waiver for each of those years, are $144.3M, $156.0M, and $168.6M (state and federal).

The state will identify individuals under 21 years of age who qualify for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and assure that EPSDT services will be provided to those individuals who qualify. In addition, if an individual is recognized as part of a Tribal Nation, the state assures that required services will be provided to qualified individuals. The methods and standards for payment are consistent with the current program: not less than (1) the federal Medicare reimbursement rate for the services provided or (2) a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

Copies of the HIP waiver renewal documents are now on file at the Indiana Family and Social Services Administration, Office of the General Counsel, 402 West Washington Street, Room 451, Indianapolis, Indiana 46204 and are open for public inspection. The documents may also be viewed at: www.HIP.in.gov

Written comments may be sent to the aforementioned address to the attention of Barbara Nardi or to barbara.nardi@fssa.in.gov through the date of the second hearing on March 22, 2013.

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January 30, 2013

Ms. Pat Casanova
Director, Office of Medicaid Policy & Planning
Family & Social Services Administration
402 W. Washington Street
Indianapolis, IN 46204

RE: 1115 WAIVER RENEWAL - BUDGET NEUTRALITY

Dear Pat:

Milliman, Inc. (Milliman) was retained by the State of Indiana, Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP) to assist in the development of the 1115 waiver filing associated with the Healthy Indiana Plan (HIP). The 1115 waiver was effective for a five-year period from calendar year 2008 through 2012, and was extended through 2013. OMPP is planning to submit a three-year waiver renewal effective January 1, 2014, proposing HIP as the coverage vehicle should Indiana choose to implement a Medicaid expansion, as authorized by the Patient Protection and Affordable Care Act (ACA). Milliman was requested to prepare the budget neutrality filing materials associated with the waiver renewal filing.

LIMITATIONS

The information contained in this letter and the attached model has been prepared for the State of Indiana, Family and Social Services Administration and Office of Medicaid Policy and Planning (OMPP), to assist with submitting financial information associated with the 1115 waiver renewal to the Centers for Medicare and Medicaid Services (CMS). The data and information presented may not be appropriate for any other purpose. The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information 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 OMPP 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.

DRAFT

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Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from projected experience.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP approved May 14, 2010.

EXECUTIVE SUMMARY

The State of Indiana filed an 1115 waiver for the Healthy Indiana Plan (HIP). The initial waiver filing was for the period of calendar year 2008 through 2012. The waiver was extended for a one year period through calendar year 2013. The State is currently submitting a waiver filing that provides for extending the waiver for an additional three years in the context of a Medicaid expansion.

The waiver renewal period corresponds with the beginning of the optional Medicaid expansion to 133% FPL, authorized by the Patient Protection and Affordable Care Act (ACA). The State of Indiana has not yet decided whether to implement a Medicaid Expansion.

Under the expansion, HIP enrollment during the waiver renewal period would be projected to increase sharply as of January 1, 2014 in order to accommodate the newly eligible. Consistent with newly eligible enrollment estimates developed for Milliman's ACA analysis, over 400,000 individuals are projected to enroll in HIP. The program would be eligible for the enhanced FMAP (100% for the waiver renewal period of calendar years 2014 – 2016).

Two other ACA-related adjustments are included in the projections effective January 1, 2014. Mandatory population enrollment reflects projected additional enrollment from populations that are currently eligible (woodwork enrollment). Also, ACA has mandated a health insurer assessment fee. Milliman has estimated that this will increase managed health plan costs by approximately 2.5%, including gross-up for taxes.

For each Demonstration Year, Table 1 illustrates the total "Without Waiver", "With Waiver", and "Waiver Margin" amounts. These are illustrated separately for the initial waiver period (with extension to six years) and the waiver renewal period.

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Table 1

State of Indiana
Office of Medicaid Policy and Planning
1115 Waiver Cost Effectiveness Summary
Initial Waiver Period and Waiver Renewal Period
{values in Millions}

Initial Waiver Period with Extension

Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Waiver Margin
2008	1	$1,722.2	$1,623.6	$98.6
2009	2	1,967.9	1,876.4	91.5
2010	3	2,159.9	1,678.8	481.2
2011	4	2,248.0	1,960.0	288.0
2012	5	2,360.9	2,363.9	(3.0)
2013	6	2,414.1	2,449.7	(35.6)
Total DY1 – DY6		$12,872.9	$11,952.3	$920.6

Waiver Renewal Period

Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Waiver Margin
2014	7	$5,258.6	$5,114.3	$144.3
2015	8	5,609.4	5,453.4	156.0
2016	9	5,984.3	5,815.7	168.6
Total DY1 – DY9		$29,725.2	$28,335.7	$1,389.5

Note: values have been rounded.

Enclosure 1 illustrates historical and projected waiver budget neutrality materials. It includes information for the initial five-year period of the waiver, the subsequent one-year extension period, and the three-year waiver renewal period.

We are also including Excel file versions of the development of the waiver cost effectiveness materials, "HIP Budget Neutrality – 2014 Renewal.xlsx".

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The following outlines the key assumptions and development associated with the waiver cost effectiveness filing.

1. **Baseline Budget Neutrality Model.** We utilized the budget neutrality model, "*IN HIP BN with 36500 noted.xls*" Excel workbook provided by CMS as the current budget neutrality model for the 1115 waiver. We have updated the model for historical experience through September 30,2012, as reported through the quarterly HIP monitoring report. The model was updated with both actual and projected experience for the five-year initial waiver period and subsequent one-year period. Projections illustrated for the initial waiver period and one-year extension are unchanged from those provided in December 19, 2012 correspondence demonstrating budget neutrality for the one-year extension period.

2. **Enrollment Growth – Mandatory Populations.** For the mandatory populations, the baseline growth trend projected for the waiver renewal period was developed using average growth rates from 2008 through 2013 (DY01 through DY06). Additional growth of approximately 92,000 adults and children has been projected to reflect health care reform (Woodwork Effect). These individuals represent approximately 75% for those who are currently eligible for Medicaid but un-enrolled.

3. **HIP Enrollment.** HIP enrollment has been projected assuming HIP is designated the vehicle for the Medicaid Expansion to 133% FPL and HIP expenditures are eligible for the enhanced FMAP. Projected newly eligible enrollment was developed based on Milliman's ACA Report dated September 18, 2012.

4. **Non-Caretaker Population – Optional Status Effective 2014.** The Adult non-Caretaker population has been illustrated as an expansion population during the initial waiver budget neutrality filing through the calendar year 2013 or DY06. Under the Affordable Care Act (ACA), the non-Caretaker population will become an optional population in calendar year 2014 or DY07. Beginning with calendar year 2014, we have included the non-Caretaker population in both the "Without Waiver" and "With Waiver" calculations.

5. **Adjustment to Test A and Test B Language.** The Special Terms and Conditions define Test A and Test B under the assumption that the HIP Caretaker population is an Optional population and the HIP Adult population is a Waiver population. The cost neutrality calculation related to Test A and Test B has been adjusted to reflect the change in status for the HIP Adult population, from a Waiver population to an Optional population. This will need to be reflected in an adjustment to the Special Terms and Conditions document, as adjusted for the renewal.

6. **Hospital Assessment Fee.** The projection reflects the implementation of a hospital rate increase for the Hoosier Healthwise population, effective July 1, 2011. The increase included a reimbursement increase for both the fee-for-service population and the managed care population. An increase was not applied for the Healthy Indiana Plan population. The increase was $593.3 million (State and Federal) in SFY 2012. The reimbursement increase funded by the Hospital Assessment Fee has been assumed to continue through the projection period (December 31, 2016).

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7. **Diverted Disproportionate Share Hospital (DSH) Payments.** The initial waiver filing included diverting DSH payments to maintain budget neutrality. This was discontinued during the one-year extension. The current waiver renewal for 2014 through 2016 also does not require diverting DSH payments to meet the budget neutrality requirement.

8. **Without Waiver Trend Rate.** The without waiver projection model requires a baseline trend rate to project future per member per month expenditures for the Mandatory and Optional populations. We have maintained the 4.4% annual trend rate for the waiver renewal periods, consistent with the trend rate for the initial waiver filing.

9. **2014 One Time Adjustment to Without Waiver Trend Rate – HIT.** Under the without waiver projections, the trend from DY 06 to DY 07 has been increased from 4.4% to 7.0% in order to reflect the health insurer assessment fee. The trend from DY 07 to DY 08 and years following has been allowed to return to the initial 4.4% included with the original filing.

10. **Physician Primary Care Fee Schedule Increase**. Hoosier Healthwise expenditures illustrated for 2013 and 2014 do not reflect an increase in the physician fee schedule to Medicare reimbursement levels for primary care physician services. This mandated reimbursement increase was not anticipated when the 4.4% annual trend rate was initially established. Consequently, the State proposes to remove related expenditures from the cost neutrality calculations and reporting.

11. **Cost per Eligible Assumptions (With Waiver Projections).**
    - **a.** Healthy Indiana Plan reimbursement is projected to remain at Medicare levels for both hospital and physician services.
    - **b.** Hoosier Healthwise reimbursement is also projected to remain at approximately the current level relative to Medicare.
    - **c.** Newly Eligible morbidity adjustment: Average HIP cost has been reduced from prior years to reflect that the newly eligible population is younger than current HIP enrollees. However, we have also included a 10% selection factor for the Caretaker / Parent population and a 20% selection factor for the non-Caretaker / Childless Adult population. The selection factors are needed because the projections do not reflect full participation. These assumptions result in projected costs that are approximately 20% lower than for current HIP enrollees.
    - **d.** HIT Adjustment: The HIT is projected to increase managed care costs by approximately 2.5%.
    - **e.** Retention of Annual and Lifetime Limits: The projections do not reflect any change to current annual and lifetime limits currently in place. Should the limits be removed, HIP cost per eligible is estimated to increase by 3%.

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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

After you have had an opportunity to review the enclosed material, please do not hesitate to contact me at 317-524-3512.

Sincerely,

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

RMD/lrb
Enclosures

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ENCLOSURE 1

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Healthy Indiana Plan *Summary Budget Neutrality Estimates - Waiver Renewal*

Scenario: Reflects experience through September 30, 2012
Updated January 30, 2013

Without Waiver Summary	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
XIX - Mandatory Populations	1,616,415,042	1,803,138,698	1,962,293,196	2,049,017,852	2,154,403,856	9,585,268,644
HIP Parents	22,228,587	70,693,403	107,249,634	117,359,803	120,745,923	438,277,350
HIP Adults	-	-	-	-	-	
DSH	83,528,693	94,035,871	90,394,363	81,584,952	85,748,289	435,292,169
Total	***1,722,172,322***	***1,967,867,972***	***2,159,937,193***	***2,247,962,607***	***2,360,898,068***	***10,458,838,163***

With Waiver Summary	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
XIX - Mandatory Populations	1,543,238,768	1,637,171,176	1,450,455,897	1,743,888,714	2,131,618,657	8,506,373,212
HIP Parents	25,142,197	72,654,464	111,694,686	123,857,471	129,574,337	462,923,156
HIP Adults	-	-	-	-	-	-
Waiver Populations	55,209,913	166,552,300	116,603,212	92,243,968	102,712,334	533,321,728
Total	***1,623,590,879***	***1,876,377,941***	***1,678,753,795***	***1,959,990,153***	***2,363,905,328***	***9,502,618,095***
Waiver Margin	***98,581,443***	***91,490,032***	***481,183,398***	***287,972,454***	***(3,007,260)***	***956,220,067***

Coverage Estimates	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
Test A						
Limit	1,699,943,735	1,897,174,570	2,052,687,559	2,130,602,804	2,240,152,145	10,020,560,813
Expenditures	1,598,448,682	1,803,723,476	1,567,059,109	1,836,132,682	2,234,330,991	9,039,694,940
Limit less Expenditures	101,495,053	93,451,094	485,628,449	294,470,122	5,821,154	980,865,873
Test B						
Limit	22,228,587	70,693,403	107,249,634	117,359,803	120,745,923	438,277,350
Expenditures	25,142,197	72,654,464	111,694,686	123,857,471	129,574,337	462,923,156
Limit less Expenditures	(2,913,610)	(1,961,062)	(4,445,051)	(6,497,668)	(8,828,414)	(24,645,805)
Combined Test A and Test B	98,581,443	91,490,032	481,183,398	287,972,454	(3,007,260)	956,220,067
Cumulative Combined Test	98,581,443	190,071,475	671,254,873	959,227,327	956,220,067	
Anticipated Enrollment						
HIP Parents	5,926	18,052	26,233	27,496	27,097	104,803
HIP Adults	9,389	26,377	18,863	14,065	14,381	83,075
Total	**15,315**	**44,429**	**45,095**	**41,561**	**41,478**	**187,879**

Healthy Indiana Plan ***Summary Budget Neutrality Estimates - Waiver Renewal***

Scenario: Reflects experience through September 30, 2012
Updated January 30, 2013

Without Waiver Summary	DY 06	DY 01 - DY 06
XIX - Mandatory Populations	2,289,771,857	11,875,040,501
HIP Parents	124,295,636	562,572,986
HIP Adults	-	-
DSH	-	435,292,169
Total	***2,414,067,493***	***12,872,905,656***

With Waiver Summary	DY 06	DY 01 - DY 06
XIX - Mandatory Populations	2,211,722,985	10,718,096,197
HIP Parents	134,330,854	597,254,009
HIP Adults	-	-
Waiver Populations	103,628,092	636,949,820
Total	***2,449,681,931***	***11,952,300,026***
Waiver Margin	***(35,614,438)***	***920,605,630***

Coverage Estimates	DY 06	DY 01 - DY 06
Test A		
Limit	2,289,771,857	12,310,332,670
Expenditures	2,315,351,077	11,355,046,017
Limit less Expenditures	(25,579,220)	955,286,653
Test B		
Limit	124,295,636	562,572,986
Expenditures	134,330,854	597,254,009
Limit less Expenditures	(10,035,218)	(34,681,024)
Combined Test A and Test B	(35,614,438)	920,605,630
Cumulative Combined Test	920,605,630	
Anticipated Enrollment		
HIP Parents	26,718	131,521
HIP Adults	14,446	97,521
Total	**41,164**	**229,042**

Healthy Indiana Plan ***Summary Budget Neutrality Estimates - Waiver Renewal***

Scenario: Reflects experience through September 30, 2012
Updated January 30, 2013

Without Waiver Summary	DY 07	DY 08	DY 09	DY 01 - DY 09
XIX - Mandatory Populations	2,795,763,755	3,001,124,284	3,221,978,632	20,893,907,172
HIP Parents	821,343,600	868,859,680	919,139,146	3,171,915,411
HIP Adults	1,641,482,400	1,739,405,581	1,843,168,314	5,224,056,296
DSH	-	-	-	435,292,169
Total	***5,258,589,755***	***5,609,389,544***	***5,984,286,093***	***29,725,171,047***

With Waiver Summary	DY 07	DY 08	DY 09	DY 01 - DY 09
XIX - Mandatory Populations	2,710,043,710	2,907,129,558	3,118,949,351	19,454,218,817
HIP Parents	762,735,600	806,865,628	853,557,502	3,020,412,739
HIP Adults	1,641,482,400	1,739,405,581	1,843,168,314	5,224,056,296
Waiver Populations	-	-	-	636,949,820
Total	***5,114,261,710***	***5,453,400,767***	***5,815,675,167***	***28,335,637,671***
Waiver Margin	***144,328,045***	***155,988,777***	***168,610,925***	***1,389,533,376***

Coverage Estimates	DY 07	DY 08	DY 09	DY 01 - DY 09
Test A				
Limit	2,795,763,755	3,001,124,284	3,221,978,632	21,329,199,340
Expenditures	2,710,043,710	2,907,129,558	3,118,949,351	20,091,168,637
Limit less Expenditures	85,720,045	93,994,725	103,029,281	1,238,030,704
Test B				
Limit	2,462,826,000	2,608,265,261	2,762,307,461	8,395,971,707
Expenditures	2,404,218,000	2,546,271,209	2,696,725,816	8,244,469,034
Limit less Expenditures	58,608,000	61,994,052	65,581,644	151,502,673
Combined Test A and Test B	144,328,045	155,988,777	168,610,925	1,389,533,376
Cumulative Combined Test	1,064,933,674	1,220,922,451	1,389,533,376	
Anticipated Enrollment				
HIP Parents	165,000	167,190	169,409	501,599
HIP Adults	262,000	265,930	269,919	797,849
Total	**427,000**	**433,120**	**439,328**	**1,299,448**

Requirement 42 CFR 431.408	State Compliance
Provide at least a 30 day comment period and public notice. Notice must include: Comprehensive program description Program goals and objectives Description of current and new beneficiaries Describe proposed health care delivery system Eligibility requirements Benefit coverage Cost-sharing Estimated expected change in annual enrollment Estimated expected change in annual expenditures Financial analysis of any changes to the demonstration Hypothesis and evaluation parameters Specific waiver and expenditure authorities Locations and internet address where copies of the demonstration application are available for public review and comment. Postal and internet e-mail address for written comments and time frame (min 30 days) for which comments will be expected. Location date and time of at least two public hearings	• Notice was published in the Indiana Register • Notice is available at HIP.in.gov via links to the FSSA calendar • Waiver documents are available at HIP.in.gov • Bobbi Nardi (Office of General Counsel) is the contact listed on the notice • Two hearings included in notice
Public notice Publish public notice process, public input process, planned hearings, the demonstration application and a link to the relevant Medicaid demonstration pages on the CMS website on main page of the public website of State agency responsible for making applications for demonstrations or on a demonstration specific webpage.	The HIP notice and all supporting documents are posted on the main page of HIP.in.gov
Public notice Publish abbreviated notice to include summary description of demonstration, location & times of two or more public hearings and an active link to full public notice document on states website Publish in the state's administrative record *or* newspapers of widest circulation in each city with a population over 100,000 provided such notice is at least 30 days prior to the submission of the demonstration application.	Completed – Used the same notice in all venues versus creating an abbreviated notice such that no matter where the notice was viewed, all information was available. The notice was published in the Indiana Register.
Public notice State must also utilize additional mechanisms such as electronic mailing list to notify interested parties of the demonstration application	OMPP issued a bulletin
Public hearings 20 days prior to submission conduct at least 2 public hearings on separate dates at separate locations Must use telephonic and/or web conference capabilities for at least two required public hearings	Hearing 1: March 20 at 1:30pm in Indiana Government Center, Conference Center Room C Hearing 2: March 22 at 1:30pm in State House room 156B Both hearings are being webcast and there is a telephone conference. The information for these is in the notice on the website
Public hearings Must use 2 of the follow public forums: Medical Care Advisory Committee Commission or other similar process option to public State legislative process Any other similar process for public input	State is using the process FSSA OGC uses for Medicaid rules, etc to gain public input. We used this for the first HIP waiver request in 2012. HIP has previously been testified on via the State legislative process, including in 2011 during the passage of SEA 2011 authorizing HIP as the healthcare reform vehicle.
Tribal consultation and seeking advice from Indiana health providers and urban Indiana organizations	IN has no Indian health providers or federally recognized tribes with a government center in IN.

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Section 11: Public Comment

FSSA held public hearings for this three-year 1115 waiver extension according the requirements under 42 CFR 431. The notice that announced two public hearings is included in Appendix A of this renewal request, and it was published in the *Indiana Register* on February 20,' 2013. The full notice was also posted on the agency's website at the web address of the 1115 waiver program's homepage: HIP.in.gov. Electronic copies of all documents related to the three year waiver extension were also available on the website. In addition, OMPP published the notice in the Indiana Health Care Provider (ICHP) Bulletin, which was sent electronically to all IHCP providers. In accordance with the notice, public hearings were conducted March 20 and 22, 2013. The hearing held on March 20 was made available to the public via a telephone conference line and a live, free webcast. The hearing held on March 22 was also made available to the public via webcast. The notice provided the option for any individual, regardless of whether he/she attended the public hearing, to submit written feedback to the State by email or by USPS mail.

Additionally, as part of the normal legislative process, hearings were held in the Senate Health and Provider Services Committee and the House Public Health Committee regarding pending legislation.[1] Legislators provided and received testimony regarding the Healthy Indiana Plan waiver and Medicaid expansion at the February 13, 2013 committee meetings, and agency staff attended these committee hearings. Many of the individuals who testified during the legislative hearings on February 13 offered public comment during the aforementioned hearings on March 20 and 22.

11.1 Summary of Public Comments

The hearings on March 20 and March 22, 2013 were held as scheduled and publicized, at the Indiana Government Center Conference facilities and the Indiana State House. Eleven individuals testified on March 20, and nine individuals testified on March 22. A court reporter transcribed both hearings. Comments were also received in writing by e-mail and regular mail. A total of twenty individuals testified at the HIP hearings, and fifty-nine written comments were received. The below summary combines the comments offered at the public hearings and via mail or email.

Over seventy-nine comments were received by the agency. The majority of comments were generally supportive of the HIP program and/or expanding Medicaid. In particular, Anthem and MDwise, two of the managed care entities (MCEs) serving HIP members, provided testimony that noted HIP enrollees are more likely to engage in care programs and follow through on personal health accountability. These entities supported HIP's consumer oriented program. They further indicated HIP's member responsibility provisions positively contribute to member health outcomes and provide evidence that a contribution model delivers cost-effective outcomes regardless of contribution level. The MCEs noted, in comparison to other Medicaid enrollees, HIP members have lower emergency room use and lower inpatient admissions, are more likely to schedule and attend physician office visits, are more engaged in their coverage options through call centers and web portals, have high rates of completion of recommended preventive services, and are more likely to comply with prescription medication regimens.

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[1] Testimony taken in regards to Senate Bill 551 and House Bill 1591.

Supportive comments were received with respect to using the HIP program to expand Medicaid. Individuals commented HIP is a landmark program. One individual noted HIP "has been a central component in the State's effort to provide quality, cost-effective health coverage for low income adults." Further testimony stated that HIP offers a foundation for the expansion of Medicaid in Indiana, and could be leveraged in an expansion to decrease costs and increase quality of care. Support was voiced for HIP's personal responsibility mechanisms, including cost-sharing mechanisms and incentives for obtaining preventive care services, and including these mechanisms in a potential Medicaid expansion.

Members of the business community, including the Indiana Chamber of Commerce and the Indiana Manufacturers Association, and provider community, including the Indiana Hospital Association, the Indiana State Medical Association, and numerous hospitals, expressed support for HIP as an innovative, consumer-directed, private market approach to expanding Medicaid. They stated any Medicaid expansion in Indiana must be aware of long term fiscal implications, and support was lent to HIP as a fiscally sound approach to a coverage expansion. Some of these organizations gave praise to HIP's ability to decrease use of the emergency room and increase use of preventive care, to improve consumer behavior including seeking the cost of procedure prior to receiving them, and to yield high enrollee satisfaction. They supported HIP's higher provider reimbursement rates and the associated decrease in cost-shifting to the private market. Additionally, some testimony noted POWER account contributions are vital to the success of the HIP program and need to remain intact to ensure the program is successful moving forward.

Comments consistently urged CMS to promptly respond to the HIP waiver request to ensure continued coverage in 2014 and to further the discussion in the state around a potential Medicaid expansion. Some individuals commented only with regards to support of a Medicaid expansion and did not address support or lack of support for the HIP program.

Five comments received in writing or through testimony expressed concern around certain features of the program including: the lifetime and annual maximums, the twelve month lock-out period for failure to pay a premium, the requirement to not have access to employer sponsored insurance, the non-caretaker waitlist, and non-provided benefits including chiropractic, dental, and vision services. These comments also addressed concerns about multiple types of coverage within a family unit and HIP integration with the federally-facilitated exchange. One commenter noted support for expansion of HIP's cost-sharing requirements to include copayments beyond the copayment for non-emergency use of the ER. Those who commented regarding the aforementioned recommendations to the program indicated support for the renewal of HIP and the use of HIP for a potential Medicaid expansion provided their concerns are addressed.

Eight comments received in writing or through testimony expressed concern about the HIP waiver renewal or use of HIP as the foundation of a Medicaid expansion. These individuals cited concerns related to: potential cost-sharing for pregnant women in HIP, co-payments for non-emergency use of the ER, the requirement for individuals to make POWER Account contributions, churn between HIP and

other Medicaid programs and the Exchange, the relative cost of HIP compared to other Medicaid programs, and the ability to scale the program to cover the entire Medicaid expansion population.

11.2 State Response to Comments

The State appreciates all comments received. In its discussions with CMS and through the potential development of the Special Terms and Conditions, the State will consider these comments in context of the outcome data around HIP's design features and the impact on the goals of the program.

The waiver request as written addresses many comments received, and the State has made no changes to this application, at this time, in response to the public comment period and public hearings. The content of this application is identical to the advanced copy application submitted to CMS on February 13, 2013.

Appendix A: 2013 Notice of Public Hearing

Notice of Public Hearing

Under 42 CFR Part 431 and the final rule under PART 431 in the February 27, 2012, issue of the Federal Register, 77 FR 11678-11700, notice is hereby given that:

(1) on March 20, 2013, at 1:30 p.m., at the Indiana Government Center South, 402 West Washington Street, Conference Center Room C, Indianapolis, Indiana; and

(2) on March 22, 2013, at 1:30 p.m., at the Indiana State House, 200 West Washington Street, Room 156B, Indianapolis, Indiana;

the Family and Social Services Administration will hold public hearings on a Medicaid 1115 waiver renewal submission to the Centers for Medicare and Medicaid Services to extend the demonstration for the Healthy Indiana Plan (HIP) for calendar years 2014-2016. The current 1115 waiver is set to expire on December 31, 2013. As a result of recent changes to Medicaid eligibility initiated by the Patient Protection and Affordable Care Act (ACA) and changes authorized by the Indiana General Assembly at IC 12-15-44.2, the waiver renewal application includes the authorized modifications to HIP, as well as requests for minimum contributions, the ability for managed care entities (MCEs) to contribute towards members' required contribution, cost-sharing changes, changes to eligibility factors, and adjustments to federal poverty level (FPL) bands.

The HIP demonstration project was approved in December 2007, and the program began on January 1, 2008. HIP currently covers nondisabled adults between the ages of 19-65 who meet the following qualifying criteria: income less than 200% FPL, no access to employer-sponsored insurance, and no health coverage within the six month period prior to application. The program includes a $1,100 deductible and creates Personal Wellness and Responsibility (POWER) accounts to fund the deductible. Individuals are required to make income driven monthly contributions to the POWER account, and the state funds the remainder of the account to ensure that the $1,100 deductible can be met. Minimal copayments of $3, $6, or $25 are charged for nonemergency use of the emergency room, per the current HIP program. In 2014, the current copayments will be replaced with a flat $8 copayment authorized by proposed federal regulations (42 CFR 447.54).

HIP is delivered via risk-based managed care and provides a basic commercial benefit package once medical costs exceed $1,100. Additionally, $500 in first dollar preventive benefits is provided at no cost to the individual. There are seven program goals in the proposed 1115 waiver application: (1) reduce the number of uninsured low-income Hoosiers, (2) reduce barriers and improve statewide access to health care services for low-income Hoosiers, (3) promote value-based decision making and personal health responsibility, (4) promote primary prevention, (5) prevent chronic disease progression with secondary prevention, (6) provide appropriate and quality-based health care services, and (7) ensure state fiscal responsibility and efficient management of the program. HIP will be evaluated based on progress towards these goals.

HIP currently covers approximately 39,000 individuals. The purpose of this 1115 waiver renewal is to continue HIP for three years to continue and to make other ACA-related changes. Changes to the program in this waiver extension, authorized in IC 12-15-44.2, include:

- A requirement for enrollees to make a minimum contribution to their POWER Account of $160 annually (but guarantees that individuals will not pay more than 5% of their income towards health costs).
- An ability for HIP-contracted MCEs to contribute to the individual's POWER account. Contributions must be linked to a health related incentive, such as completion of a risk assessment or participation in a smoking cessation program. MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's $1,100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.
- Changes HIP eligibility levels to 133% FPL (with 5% income disregard) starting on January 1, 2014. The current eligibility threshold is 200% FPL.
- Changes the requirement that to enroll in HIP an individual must have been uninsured for at least six months and not have access to employer sponsored insurance as authorized by IC 12-15-44.2.
- Changes co-payments for non-emergency use of the ER to align with proposed cost-sharing guidance.

In the first five years of the 1115 demonstration project, HIP covered 105,135 individuals. Current enrollment for the program is approximately 39,000 individuals. Based upon the financial documents prepared with the waiver, the program renewal could cover up to a total of 165,000 parents and 262,000 adults. Changes to the budget neutrality agreement have been made to reflect the ACA changes. Per the memorandum included with the waiver application "1115 Waiver Renewal-Budget Neutrality Filing", and assuming coverage for the optional Medicaid expansion population, expected expenditures are $5.1B, $5.4B, and $5.8B (state and federal) in 2014, 2015, and 2016 respectively. The expected savings, respectively, via the waiver for each of those years, are $144.3M, $156.0M, and $168.6M (state and federal).

The state will identify individuals under 21 years of age who qualify for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and assure that EPSDT services will be provided to those individuals who qualify. In addition, if an individual is recognized as part of a Tribal Nation, the state assures that required services will be provided to qualified individuals. The methods and standards for payment are consistent with the current program: not less than (1) the federal Medicare reimbursement rate for the services provided or (2) a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201306 MARCH 8, 2013

Public Hearing for HIP Program

Under *42 CFR Part 431* and the final rule under Part 431 in the February 27, 2012, issue of the *Federal Register, 77 FR 11678 - 11700*, notice is hereby given that the Family and Social Services Administration will hold public hearings on a Medicaid 1115 waiver renewal submission to the Centers for Medicare & Medicaid Services to extend the Healthy Indiana Plan (HIP) demonstration project for calendar years 2014-2016. The hearings will be held:

- On March 20, 2013, at 1:30 p.m. at the Indiana Government Center South, Conference Center Room C, 402 West Washington Street, Indianapolis, Indiana 46204-2744
- On March 22, 2013, at 1:30 p.m. at the Indiana State House, Room 156B, 200 W. Washington Street, Indianapolis, Indiana 46204-2786

A live free webcast of the event will be available and open to the public at the first hearing on March 20, 2013, at 1:30 p.m. Eastern Time, online at webinar.IN.gov/HIP. Audio may be played through a participant's computer speakers or headphones. Comments of participants can be made online via the web chat box during the hearing and will be recorded. A telephone conference line will also be available for anyone wishing to call in during the time of the hearing. The dial-in number is 1-661-673-8600, Participant Access Code: 1088925#. Participants may incur and are responsible for any long-distance telephone charges.

The current 1115 waiver is set to expire on December 31, 2013. As a result of recent changes to Medicaid eligibility initiated by the *Patient Protection and Affordable Care Act* (ACA) and changes authorized by the Indiana General Assembly at *IC 12-15-44.2*, the waiver renewal application includes the authorized modifications to HIP, as well as requests for minimum contributions, the ability for managed care entities (MCEs) to contribute toward members' required contribution, cost-sharing changes, changes to eligibility factors, and adjustments to federal poverty level (FPL) bands.

The HIP demonstration project was approved in December 2007, and the program began on January 1, 2008. HIP currently covers non-disabled adults between the ages of 19-65 who meet the following qualifying criteria: income less than 200% FPL, no access to employer-sponsored insurance, and no health coverage within the six-month period prior to application. The program includes a $1,100 deductible and creates Personal Wellness and Responsibility (POWER) accounts to fund the deductible. Individuals are required to make income-driven monthly contributions to the POWER account, and the state funds the remainder of the account to ensure that the $1,100 deductible can be met. Minimal copayments of $3, $6, or $25 are charged for nonemergency use of the emergency room, per the current HIP program. In 2014, the current copayments will be replaced with a flat $8 copayment authorized by proposed federal regulations (*42 CFR §447.54*).

HIP is delivered via risk-based managed care and provides a basic commercial benefit package once medical costs exceed $1,100. Additionally, $500 in first-dollar preventive benefits is provided at no cost to the individual. There are seven program goals in the proposed 1115 waiver application: (1) reduce the number of uninsured low-income Hoosiers, (2) reduce barriers and improve statewide access to healthcare services for low-income Hoosiers, (3) promote value-based decision making and personal health responsibility, (4) promote primary prevention, (5) prevent chronic disease progression with secondary prevention, (6) provide appropriate and quality-based healthcare services, and (7) ensure State fiscal responsibility and efficient management of the program. HIP will be evaluated based on progress toward these goals.

HIP currently covers approximately 39,000 individuals. The purpose of this 1115 waiver renewal is to continue HIP for three years and to make other ACA-related changes. Changes to the program in this waiver extension, authorized in *IC 12-15-44.2*, include:

- A requirement for enrollees to make a minimum contribution to their POWER Account of $160 annually (but guarantees that individuals will not pay more than 5% of their income toward health costs).
- An ability for HIP-contracted MCEs to contribute to the individual's POWER account. Contributions must be linked to a health-related incentive, such as completion of a risk assessment or participation in a smoking cessation program. MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's $1,100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of

harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.

- Changes HIP eligibility threshold to 133% FPL (with 5% income disregard) starting on January 1, 2014. The current eligibility threshold is 200% FPL.
- Changes the requirement that to enroll in HIP an individual must have been uninsured for at least six months and not have access to employer-sponsored insurance as authorized by *IC 12-15-44.2*.
- Changes copayments for nonemergency use of the emergency room (ER) to align with proposed cost-sharing guidance.

In the first five years of the 1115 demonstration project, HIP covered 105,135 individuals. Current enrollment for the program is approximately 39,000 individuals. Based upon the financial documents prepared with the waiver application, the program renewal could cover up to a total of 165,000 parents and 262,000 adults. Changes to the budget neutrality agreement have been made to reflect the ACA changes. Per the memorandum included with the waiver application "1115 Waiver Renewal -- Budget Neutrality Filing," and assuming coverage for the optional Medicaid expansion population, expected expenditures total $5.1B, $5.4B, and $5.8B (state and federal) in 2014, 2015, and 2016 respectively. The expected savings via the waiver for each of those years, respectively, total $144.3M, $156.0M, and $168.6M (state and federal).

The state will identify individuals under 21 years of age who qualify for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and assure that EPSDT services will be provided to those individuals who qualify. In addition, if an individual is recognized as part of a Tribal Nation, the State assures that required services will be provided to qualified individuals. The methods and standards for payment are consistent with the current program: not less than (1) the federal Medicare reimbursement rate for the services provided or (2) a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

Copies of the HIP waiver renewal documents are now on file at the Indiana Family and Social Services Administration, Office of the General Counsel, 402 W. Washington Street, Room 451, Indianapolis, Indiana 46204 and are open for public inspection. The documents may also be viewed at HIP.in.gov. Written comments may be sent to the aforementioned address to the attention of Barbara Nardi or to barbara.nardi@fssa.in.gov through the date of the second hearing on March 22, 2013.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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Benchmark Equivalent Coverage Analysis

Healthy Indiana Plan Demonstration

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March 26, 2013

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From Diane E. Heffron, February 15, 2013

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BACKGROUND

This report was developed in response to a request from the Center for Medicare and Medicaid Services (CMS). In a February 15, 2013 letter, Diane Heffron requested a benefit analysis of the Healthy Indiana Plan (HIP) section 1115 demonstration.

CMS will use this benefit analysis to determine whether coverage provided under HIP as of December 1, 2009 represented “full benefits”, “benchmark”, or “benchmark-equivalent” coverage.

The performance of this benefit analysis will not obligate Indiana to expand Medicaid.

Details of CMS’ request are included in Attachment A to this report. The report is structured in the same manner as the request.

SECTION 1 – BENEFIT ASSESSMENT TO SUBSTANTIATE NEWLY ELIGIBLE

The newly eligible FMAP is only available to states that, as of December 1, 2009, did not provide "full state plan benefits", "benchmark", or "benchmark-equivalent" coverage to low-income adults in the new adult coverage group, either through the Medicaid state plan or through a section 1115 demonstration.

As of December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relative adults (ages 19 through 64) with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to and including 200 percent of the federal poverty level (FPL).

Coverage was provided through the Healthy Indiana Plan (HIP) demonstration (Project Number 11-W-00237/5).

1. ENROLLMENT LIMIT

As of December 1, 2009, the demonstration Special Terms and Conditions restricted enrollment for non-custodial parents and childless adults to 34,000. There was no specific enrollment cap for custodial parents and caretaker relatives; although, the state was allowed to modify eligibility if funding was not available.

2. FULL BENEFITS

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not include all benefits available under the state's approved Medicaid plan. For example, HIP did not cover maternity benefits, vision benefits, dental benefits, Medicaid rehabilitation option services, chiropractic benefits, hearing aids, non-emergency transportation benefits, and others. In addition, benefit limitations often differed from those in the state plan.

HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. In addition, enrollees were required to make monthly contributions to a POWER account. Those who did not make required contribution were dis-enrolled.

3. BENCHMARK COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act.

The demonstration did not include the entire range of services offered under the three benchmark commercial packages, as in effect December 1, 2009.

The Standard BCBS PPO, as offered under the FEHBP

The demonstration did not include the entire range of service offered under the Federal Employees Health Benefit Program (FEHBP), as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. Although the FEBHP plan contains lifetime maximum benefits for specific services (for example wigs or substance abuse treatment), there is no overall lifetime maximum benefit limit.

The State Employee PPO

The demonstration did not include the entire range of service offered under the State employee PPO, as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The State Employee PPO has no annual limit, but has a lifetime benefit limit of $2,000,000 per member.

The HMO with the largest insured non-Medicaid enrollment

The demonstration did not include the entire range of service offered under the Advantage HMO, as in effect December 1, 2009. The demonstration did not include maternity services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The Advantage HMO does not have an overall lifetime maximum benefit limit.

4. BENCHMARK EQUIVALENT COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in section 1937(b)(2) of the Act.

Inclusion of Basic Services

i. Inpatient and outpatient hospital
   The demonstration package covered most inpatient and outpatient hospital services. However, Maternity services were not covered under HIP.
ii. Physicians' surgical and medical services
   The demonstration package covered physician services.
iii. Lab and x-ray services
   The demonstration package covered lab and x-ray services.
iv. Emergency services, as required in 42 CFR 440.335(b)(5)
   The demonstration package covered emergency services, as required in 42 CFR 440.335(b)(5).

42 CFR 440.335(b)(5) requires benchmark benefit packages to include coverage of essential health benefits. Please note that « Maternity and newborn care » is listed as an essential health benefit under Section 1302(b)(1)(D) of the Patient Protection and Affordable Care Act.

HIP also provides only limited coverage of another essential benefit: "Rehabilitative and Habilitative services and devices" (ACA Section 1302(b)(1)(G)). For example, HIP does not cover hearing aids, safety glasses, athletic glasses, treatment for learning disabilities, or foot care.

Aggregate Actuarial Value

The study developed an aggregate actuarial value for the Healthy Indiana Plan demonstration and each of the three benchmarks. The actuarial values are illustrated in Table 1 below.

Table 1 Actuarial Value – Aggregate Plan Healthy Indiana Plan Demonstration compared with benchmarks	
Plan	**Actuarial Value**
Standard BCBS PPO	83%
State employee plan	86%
Largest HMO	83%
HIP Demonstration	75%

The aggregate actuarial value of the demonstration is lower than all three benchmarks. The difference is larger than the +/- 2% *de minimis* standard to be used on Affordable Insurance Exchanges.

Prescription Drugs, Mental Health, Vision, or Hearing services

The actuarial value of prescription drug, mental health, vision, and hearing benefits provided by the Healthy Indiana Plan demonstration was compared to each of the three benchmarks. The actuarial values are illustrated in Table 2 below.

Table 2 Actuarial Value for Specific Services Healthy Indiana Plan Demonstration compared with benchmarks				
Plan	**Drug**	**Mental health**	**Vision**	**Hearing**
Standard BCBS PPO	82%	73%	82%	89%
State employee plan	93%	83%	82%	78%
Largest HMO	82%	54%	82%	100%
HIP Demonstration	100%	100%	0%	100%

The actuarial value calculated for each service is illustrated net of service-specific cost sharing such as copays and coinsurance, but before application of global cost sharing such as deductibles and out of pocket maximums.

The benchmark plans all include at least a basic level of vision services that allows for coverage of eyeglasses when related to an injury or specific medical condition. The demonstration does not cover vision services under any circumstances. Under section 1937(b)(2)(C) of the Act, vision service coverage for benchmark equivalent plans is required to have an actuarial value that is at least 75% of the benchmark.

The benchmark plans all make subsidized optional dental and vision plans available to members, but these optional plans have not been included in our analysis.

Actuarial Value Calculation

Milliman has provided a certificate of actuarial value of the demonstration benefit package as part of this report. The analysis conforms to the following guidelines:

i. The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.
ii. The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult population and Medicare pricing was used.
iii. The study uses a standardized population for evaluating the demonstration plan and the benchmarks. In order to be representative of the potential new adult coverage group, an adult non-Medicare population was used, with an age and gender distribution similar to that of the population that would be eligible for the new adult coverage group in Indiana. Coverage is assumed to be self-only (no family or dependent coverage).
iv. The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered and cost sharing provisions.
v. The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.
vi. The analysis reflects cost sharing requirements for each plan.

Appendix B contains actuarial cost model summaries for the HIP demonstration and each benchmark plan.

Data

CMS suggested actual claims experience from the demonstration population be used as a data source for the average utilization and cost information needed to determine actuarial value. Milliman's preliminary analysis explored this option, and identified two issues with this approach:

- The enrolled demonstration population is not representative of those who would be eligible for the new adult coverage group under a Medicaid expansion. The demonstration population is significantly older, more female, and less healthy than the population eligible for the new adult coverage group.
- The demonstration claims data does not include utilization for essential health benefits that were not covered by the demonstration benefit package. For example, because HIP does not cover benefits such as maternity care or vision, utilization of such benefits in the demonstration claims data is zero. This does not allow us to estimate the actuarial value of these benefits for benchmark plans that offer these services.

The alternative we chose was to use ***Milliman Health Cost Guidelines*** data.

The ***Guidelines*** were first developed by Milliman in 1954, and have been updated and expanded annually since that time. An extensive amount of data is used in developing the Guidelines, including published and unpublished data. The ***Guidelines*** was developed from full medical experience (hospital, physician, supplies, prescription drugs) from over 21 million lives. This is supplemented by other sources for specific services, for example a database of inpatient admissions that represents 75% of the national total.

Base utilization levels in the ***Guidelines*** are consistent with a commercial major medical plan. The utilization is summarized by age and gender, and is easily adjusted to the approximate age and gender makeup of those eligible for the new adult coverage group. Utilization is available for every service that may be offered by a benchmark plan.

Methodology

The actuarial value of the HIP demonstration and each benchmark plan was developed using a common actuarial cost model. High level results from this model are illustrated in Appendix B. The summaries illustrate all the key elements by category of service: utilization, cost per service, per member per month cost, and cost sharing value. For each service, the model illustrates estimated utilization (column 1) and average allowed cost per service (2). These are multiplied to develop the total per member per month (3) cost of benefits for each service. Through column 3, the results are identical for the demonstration and three benchmark plans. The total per member per month cost of $280.52 represents the cost

of essential health benefit coverage for the standardized population at a Medicare reimbursement. This is the denominator for each aggregate actuarial value calculation.

Column 4 illustrates the value of member cost sharing. As an example, when the plan requires the member to contribute 20% coinsurance, the cost sharing will be approximately 20% of the total value in column 3. In cases where the benefit was not covered in December 2009, the cost sharing will be equal to the total value in column 3 (for example maternity benefits for the demonstration). Column 5 illustrates the net value provided by the plan. The net per member per month cost for all services is developed by adding the cost for each individual service.

Finally, cost sharing provisions that apply across multiple service categories, such as deductibles or out of pocket maximums, are reflected. After adjustment for global cost sharing, the net per member per month cost illustrates the value provided by the plan.

The actuarial value for each plan is developed by dividing the value of benefits provided by the plan by the total per member per month cost for covering all essential health benefits ($280.52).

Demographics

The cost models used standard utilization, developed based on the ***Milliman Health Cost Guidelines*** data, with adjustment for the estimated demographics of the new adult coverage group in Indiana. This group is aged 19 to 64, with age and gender distribution as illustrated in Table 3 below.

Table 3

Age/Gender Distribution - New Adult Coverage Group

Age Bracket	Male	Female
19-25	12%	11%
25-29	6%	6%
30-34	5%	6%
35-39	4%	5%
40-45	4%	6%
45-49	4%	4%
50-54	5%	4%
54-59	3%	4%
60-64	4%	6%

Those eligible for the new adult coverage group were estimated based on 2011 American Community Survey data from the U.S. census bureau. We selected individuals aged 19 – 64 who were not already covered by Medicare or Medicaid and had incomes below 138% of poverty guidelines. Also excluded were individuals in group quarters: college students, nursing home residents, and incarcerated individuals. We have found that college students often appear to have improperly low incomes because they have not been grouped with their parents. And finally, the estimated new adult coverage group also excludes adults who are currently eligible for Medicaid but enrolled: custodial adults with incomes below the AFDC income limits.

Pricing and Other Assumptions

Pricing in the models has been adjusted to Medicare levels for all plans. This is the pricing level used for the HIP demonstration. Pharmacy reimbursement has been assumed to be the Average Wholesale Price (AWP) less 18% for brand name drugs, and AWP less 65% for generics. A $2 dispensing fee has also been incorporated in the cost.

No adjustment has been made to reflect differing degrees of health care management, including utilization control, prior authorizations, or other delivery system variations.

Cost sharing provisions for each plan are reflected in the models.

Analysis of Results

In general, the benchmark plans covered a wider range of services, most notably maternity benefits.

Adjustments for the value of the cost sharing did not change the relative positions of the plans. Although the benchmark plans have higher copays and coinsurance, the demonstration has the highest deductible.

The remainder of this section discusses the actuarial value by category of service. Please refer to the actuarial cost model summaries in Appendix B.

Inpatient Facility benefits

As for all services, utilization (column 1), average allowed cost (2) and total per member per month cost (3) are the same for all plans. The total monthly value of these services before cost sharing is estimated as $46.09 for all plans.

The benchmark plans had relatively low cost sharing for this category of service:

- The FEHBP required a $200 copay per admission. The copay is waived for maternity admissions.
- The State employee plan required a $500 copay per admission.
- The HMO required a $250 copay per admission.
- The HIP demonstration did not cover maternity services. This is illustrated as 100% cost sharing for this service line. There are no other copay or coinsurance requirements for inpatient hospital services. However, these services were subject to the $1,100 deductible.

Outpatient Facility benefits

The total monthly value of outpatient facility services before cost sharing is estimated as $60.18 for all plans.

Cost sharing is reflected as follows:

- The FEHBP required 15% coinsurance
- The State employee PPO required $75 copays for emergency room services, $250 copays for outpatient surgery, and 20% coinsurance applied to other services.
- The HMO required $125 copays for outpatient surgery and emergency room visits, $35 copays for therapy, mental health, and substance abuse visits, and an additional $50 copay for certain types of imaging. Other services were subject to 20% coinsurance.
- The HIP demonstration required a $3 to $25 copay for emergency room services. Also, all costs other than preventive services were subject to the deductible.

Professional

The total monthly value of professional services before cost sharing is estimated as $76.41 for all plans.

Cost sharing generally reflected a mixture of copays and coinsurance and can be summarized as follows:

- The FEHBP required $20 copays for most office visits, and 15% coinsurance for other services. Cost sharing was waived for maternity services.
- The State employee PPO required $20 copays for office visits, and 20% coinsurance applied to other services. Cost sharing was waived for preventive services.
- The Advantage HMO did not cover chiropractic services. These are illustrated as 100% patient responsibility. In general, the HMO applied $20/$35 primary care/specialist copays to office visits, including mental health and substance abuse visits, with $50 copays for urgent care visits. 20% coinsurance applied to other services. Cost sharing is reduced for maternity services (only applies to the first prenatal visit).
- The HIP demonstration did not cover maternity or chiropractic services. These are illustrated as 100% patient responsibility. Also, all costs other than preventive services were subject to the $1,100 deductible.

Other

The total monthly value of professional services before cost sharing is estimated as $97.84 for all plans, mainly attributable to prescription drugs.

Prescription drug cost sharing provisions can be summarized as follows:

- When purchased retail, the FEHBP required 20% coinsurance for generics and 30% for brand drugs. Mail order purchases allowed for a 90-day supply: $10 for generics and $65 for brand name drugs. We have assumed an even mix of purchase types (mail order/retail).
- The State employee PPO required $10 copays for generic drugs, $20 for brand drugs.
- The Advantage HMO required $10 or $20 copays for generic drugs and $30 for brand drugs.
- The HIP demonstration had no copays for drugs. They were subject to the $1,100 deductible.

The HIP demonstration did not provide dental or vision benefits. The benchmark plans covered a minimal level of vision and dental benefits in order to cover accidental injury or glasses needed for a medical condition. The benchmark plans also subsidize stand-alone supplemental vision and benefit plans for members, but these are not valued as part of this analysis.

Global Cost Sharing Adjustments

The value of global cost sharing provisions, such as deductibles and out of pocket maximums, was developed using a claims probability distribution. Although average per member per month values are illustrated for each service, the majority of members do not incur any claims at all during a given month, and those members who do incur claims tend to incur costs that are higher than the average.

The deductible serves to shift a portion of first dollar costs from the plan to the member, reducing actuarial value. It has a greater impact for HIP demonstration members than for benchmark plan members. This is because:

- Except for preventive services, all demonstration services are subject to the deductible. The benchmark plans have many commonly provided services, most notably hospital, prescription drugs and office visits, that are not subject to the deductible because they are subject to copays instead.
- The demonstration's deductible is higher than for the other plans.

The out of pocket maximum serves to protect members who incur large costs, adding to the value of the plan. The value of this provision is largest for the State PPO, as their members only have to incur $2,000 in out of pocket expenses - $500 deductible plus $1,500 additional – before the out of pocket maximum kicks in. It is less valuable for the FEHBP, whose members need to pay $5,000 out of pocket before the maximum is reached. And it has almost no value at all for HIP demonstration members because after the $1,100 deductible has been paid, there are no additional opportunities for cost sharing (no other copays or coinsurance except for a minimal copay related to emergency services.)

SECTION II – BENEFIT ASSESSMENT TO SUBSTANTIATE EXPANSION STATE FMAP

In the previous section, the State of Indiana has determined that the Healthy Indiana Plan (HIP) section 1115 demonstration did not provide full benefits, benchmark benefits, or benchmark equivalent benefits. The State has not prepared a response to Section II due to the results of the analysis presented in Section I.

CERTIFICATE OF ACTUARIAL VALUE OF THE DEMONSTRATION PACKAGE

ACTUARIAL CERTIFICATION

The authors of this study, Robert Damler, and Christine Mytelka, are consulting actuaries with the firm of Milliman, Inc. We were retained by the State of Indiana, Office of Medicaid Policy and Planning, to perform a benchmark equivalent coverage analysis for the Healthy Indiana Plan (HIP) demonstration.

The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.

The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult commercial population, and Medicare pricing was used.

The study uses a standardized population for evaluating the demonstration plan and the benchmarks. A non-Medicare adult population was used, with standard age and gender distribution. Coverage is assumed to be self-only (no family or dependent coverage).

The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered, benefit limitations, and cost sharing provisions.

The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.

The analysis reflects the increase in actuarial value of benefits resulting from limitations on cost sharing.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

[redacted]

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

March 26, 2013

Date

[redacted]

Christine Mytelka, FSA, MAAA
Consulting Actuary

March 26, 2013

Date

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration and Office of Medicaid Policy and Planning (OMPP), to assist with submitting benefit information associated with the Healthy Indiana Plan 1115 demonstration to the Centers for Medicare and Medicaid Services (CMS). The data and information presented may not be appropriate for any other purpose.

The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information 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 OMPP 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 the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP approved May 14, 2010.

Appendix A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

FEB 15 2013

Patricia Casanova
Director
Office of Medicaid Policy and Planning
Family and Social Services Administration
402 West Washington Street, PO Box 7083
Indianapolis, IN 46207-7083

Dear Ms. Casanova:

CMS recently issued Questions and Answers, which can be found at http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf, to provide states with more information about the availability of increased federal medical assistance percentages (FMAPs, or federal match) provided in the Affordable Care Act. We are writing to provide additional guidance to Indiana on the availability of the "newly eligible" and/or "expansion state" FMAP given that Indiana provided coverage to low-income adults through its Healthy Indiana Plan (HIP) section 1115 demonstration prior to the enactment of the Affordable Care Act. Specifically, we wanted to describe how we will work with you to determine whether demonstration populations will be eligible for the newly eligible, expansion state or regular FMAP, if your state decides to adopt the new adult coverage group. More guidance about the method states will use to distinguish among populations for purposes of applying the appropriate FMAP will be provided in forthcoming FMAP final regulations.

As you know, beginning in 2014 the Affordable Care Act authorizes two types of increased federal Medicaid matching rates for state expenditures for low-income individuals in the new adult group (that is, the group described by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act)): the newly eligible FMAP and the expansion state FMAP. Under the statute, these two increased federal matching rates are only available to states that adopt the new adult group.

- The newly eligible FMAP is available to all states, including those identified as expansion states, for expenditures for individuals in the new adult group who would not be eligible for full state plan, benchmark, or benchmark-equivalent Medicaid benefits under state rules in effect as of December 1, 2009. This includes expenditures for individuals that would have been eligible for such coverage, but were not enrolled due to enrollment limitations under the demonstration.
- The expansion state FMAP is available to qualifying states for expenditures for certain nonpregnant childless adults (those who are enrolled in the new adult group and who the state may require to enroll in benchmark coverage), to the

extent that such individuals do not qualify for the newly eligible FMAP. A qualifying state is a state that, as of March 23, 2010 (the date of enactment of the Affordable Care Act), had provided a specified level of health benefits coverage, which we refer to as "specified" coverage,[1] (whether through Medicaid or a fully state-funded program) statewide to both low-income parents and nonpregnant childless adults up to at least 100 percent of the federal poverty level (FPL).

The newly eligible and expansion state FMAP definitions reference different coverage dates and different scopes of benefits, thus requiring different analyses to confirm their application. To the extent that the definitions overlap for a particular population, so that either the newly eligible or the expansion state FMAP could apply in a state designated as an expansion state, expenditures would be matched at the higher applicable FMAP; being an expansion state will not be a disadvantage in terms of matching rates for that population. It is important to also note that the expenditures for some populations in the new adult group (for example, parents who were previously eligible for full state plan benefits) may be matched at your regular FMAP.

We will work with you and your staff to ensure that the correct FMAP is applied to expenditures for each population. When we approved the HIP demonstration, we did not explicitly designate the coverage offered under your accepted Special Terms and Conditions (STCs) as "benchmark" or "benchmark-equivalent" coverage, even though the coverage offered to demonstration beneficiaries may have met such standards. Therefore, to reach a final FMAP determination for your state, we are requesting that you provide certifications about eligibility and benefits in effect as of dates specified in the Affordable Care Act.

In particular, we request that you provide a benefit analysis that includes the information described in Attachment A to enable CMS to confirm whether coverage provided to each demonstration population as of December 1, 2009 represents "full benefits," "benchmark," or "benchmark-equivalent" coverage. (Additional information on the statutory benchmark standards that were in effect on December 1, 2009 can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Benchmark-Standards-12-1-09.pdf). If the demonstration coverage is found not to have met a benchmark or benchmark-equivalent coverage standard, Indiana will qualify for the newly eligible FMAP for relevant populations. As noted above, Attachment A provides a guide for you and your staff to use to as you conduct your benefit analyses. Completion of the guide is not required as it is merely a form to use at your option; however, the type of information contained in it is needed for CMS to confirm your applicable FMAPs.

If the newly eligible FMAP is not available for a particular population, you may be able to claim the expansion state FMAP for certain nonpregnant childless adults covered in

[1] The standards for specified coverage are set forth in section 1905(z)(3) of the Act statewide; it is coverage that included inpatient hospital services, was not dependent on access to employer coverage, employer contribution, or employment, and was not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits authorized under a demonstration program authorized under section 1938 of the Act.

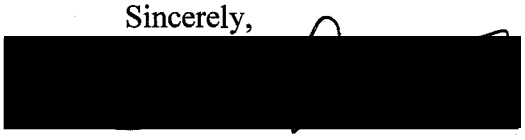
the new adult group. The benefit analysis described in Attachment A is necessary for you to establish Indiana's status as an expansion state so that we can apply the expansion state FMAP to appropriate expenditures. As noted above, status as an expansion state will not negatively affect your ability to claim the newly eligible FMAP. The expansion state FMAP will apply only when the newly eligible FMAP is not applicable for a particular population.

Attachment A provides additional detail about the methodology and data necessary to substantiate your analysis. For example, the state's benchmark equivalence analyses must be certified by a qualified actuary and must include information on the data, assumptions, and methodology used to calculate actuarial values, as described in Attachment A. We will use the benefit analyses information provided to determine the appropriate FMAP. Upon reviewing your benefit analyses, we may seek additional information and/or clarification.

Given that Indiana expanded coverage prior to the enactment of the Affordable Care Act, we encourage you to analyze your demonstration's benefits using the guide found in Attachment A and to submit your analyses to CMS. We understand that you may have not made a decision about whether and/or when to adopt the new adult coverage category and submission of your analysis will not obligate Indiana to any particular decision. Rather, providing this information will enable CMS to provide you with information about the FMAP(s) that might apply depending on the state's decision.

We are committed to reviewing your information and working with you and your staff to confirm the applicable FMAPs in a timely manner. We encourage you to submit your analysis to Allison Orris at Allison.Orris@cms.hhs.gov by April 15, 2013. Please work with your State Operations and Technical Assistance (SOTA) team, or contact Allison Orris if you have any questions.

Sincerely,



Dianne E. Heffron
Director
Financial Management Group

Attachment

Attachment A: Guide to Demonstration Benefit Analysis

cc:

Verlon Johnson, Associate Regional Administrator, Division of Medicaid and Children's Health Operations

Barbara Edwards, Director, Disabled and Elderly Health Programs Group

Jennifer Ryan, Acting Director, Children and Adults Health Programs Group

Attachment A - Guide to Demonstration Benefit Analysis

This Attachment provides a guide for the state to use to conduct the benefit analysis for purposes of determining which FMAPs may apply for adult populations provided coverage through section 1115 demonstrations prior to enactment of the Affordable Care Act. Use of this guide is not required; however, the information contained below will help CMS to confirm the applicable FMAPs. A separate analysis should be undertaken for each demonstration group, if different demonstration populations received different benefits under the demonstration and/or if different enrollment caps or limitations applied to different groups. CMS may request additional information to address specific questions; the below questions represent a uniform starting point for analysis.

Section I – Benefit Assessment to Substantiate Newly Eligible FMAP

The newly eligible FMAP is only available to states that did *not* provide "full state plan benefits," "benchmark" or "benchmark-equivalent" coverage to low-income adults either through the Medicaid state plan or through a section 1115 demonstration. To determine if demonstration-based coverage could have been designated as benchmark or benchmark-equivalent coverage, the following questions (based on section 1937 of the Act, as it was in effect on December 1, 2009, and our regulation at 42 CFR 440.330-340) should be considered as part of the state's analysis.

> According to our preliminary review, on December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relatives with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to 200 percent of the FPL through the Healthy Indiana Plan demonstration (Project Number 11-W-00237/5). If this is incorrect, please provide the correct demonstration name, project number and/or covered populations.

1. Was the demonstration, as in effect on December 1, 2009, authorized to limit enrollment?

> If applicable, please specify the enrollment cap authorized by the demonstration as of December 1, 2009, and the actual enrollment, as calculated per the reporting requirements specified under the demonstration, if different.

2. **Full Benefits:** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "full benefits" meaning, with respect to each demonstration group, medical assistance for all services covered under the state's approved Medicaid state plan?

[If the answer to question 2 is "yes," skip to Section II to establish whether "expansion state" status is applicable.]

3. **"Benchmark Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark coverage" described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation, and include any applicable citations to the demonstration's special terms and conditions (STCs) that were in effect on December 1, 2009:

3a. Did the demonstration benefit package include the entire range of services offered under any of the following three commercial products, as they were in effect on December 1, 2009? (States that are unable to locate health plan information from 2009 should contact CMS for technical assistance.)

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

[If the answer to question 3a is "no," continue to question 4.]

4. **"Benchmark Equivalent Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark equivalent coverage" described in section 1937(b)(2) of the Act that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation:

4a. Did the demonstration benefit package provide all of the following services?

i. Inpatient and outpatient hospital,
ii. Physicians' surgical and medical services,
iii. Lab and x-ray services, and
iv. Emergency services, as required in 42 CFR 440.335(b)(5)

4b. In addition to the services mentioned above, did the demonstration benefit package have an aggregate actuarial value that is at least actuarially equivalent to one of the three following commercial products:

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

4d. If the commercial product selected for actuarial comparison contained prescriptions drugs, mental health services, vision or hearing services as of December 1, 2009, did the demonstration benefit package offer such coverage to have an actuarial value of at least 75 percent of the actuarial value of the coverage

for that category of service in the benchmark plan used for comparison by the state?

4e. Has the state obtained a certificate of actuarial value of the demonstration benefit package adhering to the requirements above, completed by an individual who is a member of the American Academy of Actuaries, and that meets the following elements?

i. Uses generally accepted actuarial principles and methodologies;
ii. Uses a standardized set of utilization and price factors;
iii. Uses a standardized population that is representative of the population involved;
iv. Applies the same principles and factors in comparing the value of different coverage (or categories of services);
v. Does not take into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
vi. Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage. This is important especially since Medicaid typically has minimal or no cost sharing requirements (even if they may be more extensive in waiver plans) while the benchmark plans may have higher levels of cost sharing.

In conducting the foregoing analysis, it will be important to utilize a consistent methodology and provide CMS with sufficient data to substantiate the states' conclusions. Following the below guidelines will assure CMS' ability to validate states' analysis:

- The analysis should specify the source of data used to calculate the actuarial value of the plans. We recommend using recent actual claims experience from beneficiaries in the demonstration to conduct the analysis. If other data is used, the data should be for a comparable population (which may include age, gender, geography, and health and disability status amongst other factors); the report should also state why this data source was used.

- The methodology to calculate actuarial value and equivalence should also be specified in the analysis. The following factors should be considered in the methodology:
  - The methodology should use a standard set of prices or reimbursement rates for the different plans. In other words, the differences between the prices paid between the plans should not be considered as a source of difference in actuarial value between the plans.
  - The methodology should consider differences between the cost sharing requirements of the plans. The actuarial value should be based on the

value of the benefits paid by the plan rather than on the value of the allowed benefits of the plans.
  - The methodology should also consider other relevant differences between the plans. This should include differences in values that result from benefits offered in the demonstration plan and not in the benchmark plans and vice versa (benefits offered in the benchmark plans but not in the demonstration plan).

- When determining whether the demonstration plan, as in effect on December 1, 2009, and the benchmark plans are actuarially equivalent, we consider a plan that has an actuarial value equal to another plan's value plus or minus 2 percent to be actuarially equivalent. This standard, which we are adopting for benchmark equivalence comparisons for purposes of assigning the newly eligible FMAP only, is based on and consistent with the November 26, 2012 proposed rule "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." The Center for Consumer Information and Insurance Oversight proposes to apply this +/- 2 percent *de minimis* standard to determine whether plans that will be offered on Affordable Insurance Exchanges are actuarially equivalent. Because measuring the actuarial value of plans may not be precise, particularly in cases where there are significant differences in the benefits and plan design between the demonstration plan and the benchmark plans, it is reasonable to allow for a range around the actuarial values of the plan rather than require a precise equality.

In communicating the results of this analysis, you should submit a report certified by an actuary (as described above) that contains at a minimum the following information:

- The data used in the analysis;
- The methodology used in the analysis;
- The actuarial values of the demonstration plan and the benchmark plans, and;
- An analysis of the differences in actuarial values of the demonstration plan and the benchmark plans if the demonstration plan is found not to be at least actuarially equivalent to the benchmark plans. This analysis should discuss the main reasons for the differences (for example, differences in services covered; differences in cost sharing and plan design; other key differences between the plans) as well as the relative contribution of the major differences between the plans.

Finally, as noted above, for demonstrations that have separate populations and benefit plans, an analysis should be provided for each population or plan. These analyses may be presented within the same report or in separate reports.

Section II – Benefit Assessment to Substantiate Expansion State FMAP

If, after completing the newly eligible benefit assessment described above, you determine that full benefits, benchmark benefits, or benchmark equivalent benefits were provided, and that the newly eligible FMAP is therefore not available for some or all demonstration

populations, you should answer the following questions in order to substantiate possible eligibility for the expansion state FMAP, if applicable.

In answering the questions below, please cite the applicable STC or state-based policy.

1. Did Indiana provide coverage to parents and childless adults up to at least 100 percent of poverty, as of March 23, 2010?

   If Indiana did provide coverage, please answer questions (a) through (c) below:

   a. What was the upper income level of coverage for parents as of March 23, 2010? How many people received such coverage?

   b. What was the upper income level for coverage of childless adults as of March 23, 2010? How many people received such coverage?

   c. If coverage was provided through a section 1115 demonstration, please provide the demonstration's name and project number; if through a state-only program, please identify the state-only program.

2. Was this coverage offered on a statewide basis?

3. What was the scope of coverage provided to these populations?

   a. Did the coverage include inpatient hospital services?

   b. Was the coverage dependent on access to employer coverage, employer contribution, or employment?

   c. Was the coverage limited to premium assistance, hospital-only benefits, a high deductible health plan, or a health opportunity account?

Appendix B

Indiana Medicaid

FEHB Plan - Standard Option
$300 Deductible / 15% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.37	$12.48	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.31	24.27	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.09	1.71	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.00	6.36	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$0.77	$45.32	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.19	$10.70	
Surgery			142 cases	1,934.79	22.90	3.43	19.47	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	1.76	10.02	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.06	0.35	
Preventive			329 cases	54.83	1.50	0.23	1.27	
Other Outpatient Facility			582 cases	241.40	11.70	1.85	9.85	
					$60.18	$8.52	$51.66	
Professional								
Surgery			746 proced	$360.78	$22.43	$3.36	$19.07	
Maternity			50.0 proced	784.51	3.26	0.00	3.26	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.42	5.53	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.19	5.93	
Preventive			1,394 proced	32.04	3.72	2.32	1.40	
Consults			862 visits	90.63	6.50	0.85	5.65	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	1.21	1.44	
Hearing and Speech Exams			21 visits	51.35	0.09	0.01	0.08	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	2.64	14.92	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.03	1.17	
					$76.41	$17.96	$58.45	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.51	$75.25	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.09	0.54	
Ambulance			22 cases	737.04	1.35	0.14	1.21	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.42	2.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.86	0.29	
Other - Total					$97.84	$18.04	$79.80	
Total Medical Cost					$280.52	$45.29	$235.23	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$100.03	
Value of $300 Deductible							(9.87)	
Value of $4,700 Out-of-Pocket Maximum after deductible							8.02	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$98.18	
PMPM for Services Not Subject to Deductible							$135.20	
Total Medical Cost After Deductible and Coinsurance							$233.38	83.2%

Prescription Drugs	$75.25	$91.76	82.0%
Mental Health Services	3.23	4.41	73.2%
Vision	0.09	0.11	81.8%
Hearing	0.08	0.09	88.9%

Indiana Medicaid

State Employee PPO
$500 Deductible / 20% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.93	$11.92	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.78	23.80	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.22	1.58	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.81	5.55	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.05	0.45	
	66.7 Admits	4.96	330.9 days		$46.09	$2.79	$43.30	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.31	$10.58	
Surgery			142 cases	1,934.79	22.90	2.96	19.94	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	2.35	9.43	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.09	0.32	
Preventive			329 cases	54.83	1.50	0.30	1.20	
Other Outpatient Facility			582 cases	241.40	11.70	2.34	9.36	
					$60.18	$9.35	$50.83	
Professional								
Surgery			746 proced	$360.78	$22.43	$4.49	$17.94	
Maternity			50.0 proced	784.51	3.26	0.65	2.61	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.57	5.38	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.43	5.69	
Preventive			1,394 proced	32.04	3.72	0.74	2.98	
Consults			862 visits	90.63	6.50	0.83	5.67	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	0.53	2.12	
Hearing and Speech Exams			21 visits	51.35	0.09	0.02	0.07	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	3.52	14.04	
Chiropractor			564 visits	19.82	0.93	0.19	0.74	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.44	1.76	
					$76.41	$17.41	$59.00	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$6.37	$85.39	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.07	0.56	
Ambulance			22 cases	737.04	1.35	0.09	1.26	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.57	2.27	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.31	0.84	
Other - Total					$97.84	$7.43	$90.41	
Total Medical Cost					$280.52	$36.98	$243.54	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$73.66	
Value of $500 Deductible							(12.15)	
Value of $1,500 Out-of-Pocket Maximum after deductible							10.72	
Value of $2,000,000 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$72.23	
PMPM for Services Not Subject to Deductible							$169.88	
Total Medical Cost After Deductible and Coinsurance							$242.11	86.3%

Prescription Drugs	$85.39	$91.76	93.1%
Mental Health Services	3.66	4.41	83.0%
Vision	0.09	0.11	81.8%
Hearing	0.07	0.09	77.8%

Company Name

Advantage HMO
$250 Deductible / 50% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.46	$12.39	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.39	24.19	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.11	1.69	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.40	5.96	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$1.36	$44.73	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$2.18	$9.71	
Surgery			142 cases	1,934.79	22.90	1.48	21.42	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.28	11.50	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.18	0.23	
Preventive			329 cases	54.83	1.50	0.00	1.50	
Other Outpatient Facility			582 cases	241.40	11.70	1.35	10.35	
					$60.18	$5.47	$54.71	
Professional								
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43	
Maternity			50.0 proced	784.51	3.26	0.04	3.22	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	5.81	4.14	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.07	6.05	
Preventive			1,394 proced	32.04	3.72	0.00	3.72	
Consults			862 visits	90.63	6.50	0.35	6.15	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	2.11	0.54	
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.72	0.48	
					$76.41	$12.03	$64.38	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.90	$74.86	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63	
Ambulance			22 cases	737.04	1.35	0.27	1.08	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	1.42	1.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.39	0.76	
Other - Total					$97.84	$19.00	$78.84	
Total Medical Cost					$280.52	$37.86	$242.66	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$28.94	
Value of $250 Deductible							(8.69)	
Value of $0 Out-of-Pocket Maximum after deductible							0.00	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$20.25	
PMPM for Services Not Subject to Deductible							$213.72	
Total Medical Cost After Deductible and Coinsurance							$233.97	83.4%

Prescription Drugs	$74.86	$91.76	81.6%
Mental Health Services	2.40	4.41	54.4%
Vision	0.09	0.11	81.8%
Hearing	0.09	0.09	100.0%

Indiana Medicaid

Healthy Indiana Plan Demonstration

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost
Inpatient Facility							
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.00	$12.85
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.00	24.58
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.00	1.80
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	6.36	0.00
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50
	66.7 Admits	4.96	330.9 days		$46.09	$6.36	$39.73
Outpatient Facility							
Emergency Room			209 cases	$682.75	$11.89	$0.05	$11.84
Surgery			142 cases	1,934.79	22.90	0.00	22.90
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.00	11.78
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.00	0.41
Preventive			329 cases	54.83	1.50	0.00	1.50
Other Outpatient Facility			582 cases	241.40	11.70	0.00	11.70
					$60.18	$0.05	$60.13
Professional							
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43
Maternity			50 proced	784.51	3.26	3.26	0.00
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	0.00	9.95
Miscellaneous Medical			1,642 proced	51.98	7.12	0.00	7.12
Preventive			1,394 proced	32.04	3.72	0.00	3.72
Consults			862 visits	90.63	6.50	0.00	6.50
Vision			0 visits	0.00	0.00	0.00	0.00
Physical Therapy			723 visits	44.00	2.65	0.00	2.65
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56
Chiropractor			564 visits	19.82	0.93	0.93	0.00
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.00	2.20
					$76.41	$4.19	$72.22
Other							
Prescription Drugs			12,122 scripts	$90.84	$91.76	$0.00	$91.76
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63
Ambulance			22 cases	737.04	1.35	0.00	1.35
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.00	2.84
Glasses/Contacts			10 cases	135.60	0.11	0.11	0.00
Dental Benefits			133 cases	104.07	1.15	1.15	0.00
Other - Total					$97.84	$1.26	$96.58
Total Medical Cost					$280.52	$11.86	$268.66
Starting Net PMPM Claim Cost for Services Subj to Ded.							$264.60
Value of $1,100 Deductible							(55.26)
Value of $0 Out-of-Pocket Maximum after deductible							0.00
Value of $300,000 Annual Maximum							(2.61)
Adjusted Net PMPM for Services Subject to Deductible							$206.73
PMPM for Services Not Subject to Deductible							$4.06
Total Medical Cost After Deductible and Coinsurance							$210.79 75.1%

Prescription Drugs	$91.76	$91.76	100.0%
Mental Health Services	4.41	4.41	100.0%
Vision	0.00	0.11	0.0%
Hearing	0.09	0.09	100.0%

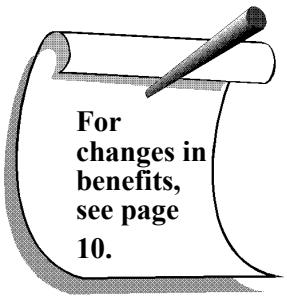
Appendix C

Blue Cross® and Blue Shield® Service Benefit Plan

http://www.fepblue.org

2009

A fee-for-service plan (standard and basic option) with a preferred provider organization



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHB

Enrollment codes for this Plan:

104 Standard Option - Self Only
105 Standard Option - Self and Family
111 Basic Option - Self Only
112 Basic Option - Self and Family

ACCREDITED HEALTH WEB SITE

ACCREDITED CASE MANAGEMENT

This Plan has Health Web Site and Case Management accreditation from URAC. See the 2009 FEHB Guide for more information on accreditation.

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Center for Retirement and Insurance Services
http://www.opm.gov/insure

RI 71-005

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier). The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on pages 9 and 10. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.

If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

Ø www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this fee-for-service Plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact your Local Plan to request a PPO directory.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. We refer to PPO facility and professional providers as "Preferred." They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under Standard Option only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities. They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see page 124). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 14 for the exceptions to this requirement.

Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

General features of our High Deductible Health Plan (HDHP)

The Blue Cross and Blue Shield Service Benefit Plan Basic Option includes a sub-option called Basic Consumer Option. This High Deductible Health Plan (HDHP) is available to members who reside in Ohio; Minnesota; Tennessee; the counties of Johnson and Wyandotte in Kansas; and, in the following counties of Missouri: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, and Worth. As with other FEHB HDHPs, our Basic Consumer Option features a calendar year deductible and an annual out-of-pocket maximum limit that are higher than other types of FEHB plans. Also, as with other FEHB Program HDHPs, our Basic Consumer Option also offers tax-favored Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs). Please see below for more information about these savings features. For detailed information about the Basic Consumer Option, please refer to the *Addendum Summarizing the Basic Consumer Option Program.*

Preventive care services

Under Basic Consumer Option, preventive care services performed by Preferred providers are paid as first dollar coverage, i. e., you pay nothing for covered services. You must use Preferred providers in order to receive benefits. See page 14 of the Service Benefit Plan brochure for the exceptions to this requirement.

Annual deductible

You must meet the Basic Consumer Option calendar year deductible before we provide benefits for non-preventive medical care. The annual deductible is $2,900 for Self Only coverage and $5,800 for Self and Family coverage.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), are not enrolled in Medicare, have not received VA benefits within the last three months, are not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- You cannot make contributions to an HRA.
- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket maximum amount for covered services is the same as your annual deductible amount: $2,900 for Self Only coverage and $5,800 for Self and Family coverage. Therefore, if you have met your annual deductible, you have also satisfied your annual maximum for out-of-pocket expenses. Your care must be provided by Preferred providers (and Non-preferred providers that meet the exception situations listed in this brochure).

Health education resources and accounts management tools

You can find information about Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) on our Web site at www.fepblue.org. You can also access your HSA or HRA account balance in addition to your complete claims reimbursement payment history from Blue Healthcare Bank through our Web site. Blue Health Connection offers health advice and counseling in addition to information on general health topics, health care news, specific diseases, first aid, drug/medication interactions, children's health, and patient safety. You may contact Blue Health Connection by calling 1-888-258-3432 toll-free, or accessing our Web site, www.fepblue.org.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (Benefits). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- In Section 3, under **Covered professional providers**, Illinois has been added to the list of medically underserved areas for 2009. (See page 12.)

Changes to this Plan

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 134.)
- Your $10 copayment for generic drugs purchased through the Mail Service Prescription Drug Program is now waived for the first 4 generic prescriptions filled (and/or refills ordered) per calendar year. (See page 92.)
- Your coinsurance amount for generic drugs purchased at Preferred Retail Pharmacies is now 20% of the Plan allowance. In addition, your coinsurance amount for brand-name drugs is now 30% of the Plan allowance. Previously, you paid 25% of the Plan allowance for generic drugs and 25% of the Plan allowance for brand-name drugs. (See page 91.)
- We clarified that Prescription Drug Benefits are available for diabetic test strips. (See page 90.)
- Your copayment for brand-name drugs purchased through the Mail Service Prescription Drug Program is now $65 per prescription for the first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year and $50 per brand-name prescription/refill thereafter. Previously, your copayment was $35 per brand-name prescription. (See page 92.)
- The catastrophic out-of-pocket maximum for deductibles, coinsurance, and copayments is now $5,000 per year when you use Preferred providers and $7,000 per year when you use a combination of Preferred and Non-preferred providers. Previously, the out-of-pocket maximum was $4,500 for Preferred provider services and $6,500 for both Preferred and Non-preferred provider services. (See page 21.)
- You now pay 15% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are also responsible for any difference between our allowance and the billed amount. Previously, you paid 10% of the Plan allowance. (See pages 28 and 51.)
- Your copayment for office visits to Preferred providers is now $20 per visit. Previously, you paid $15 per visit. [See Sections 5(a), 5(d), and 5(e).]
- Your coinsurance amount for office visits to Non-preferred providers is now 30% of the Plan allowance. Previously, you paid 25% of the Plan allowance. [See Sections 5(a), 5(d), and 5(e).]
- Your coinsurance amount for certain Preferred professional services is now 15% of the Plan allowance. In addition, your coinsurance amount for certain Non-preferred professional services is now 30% of the Plan allowance. Previously, you paid 10% of the Plan allowance for Preferred provider services and 25% of the Plan allowance for Non-preferred provider services. [See Sections 5(a), 5(b), 5(d), and 5(e).]
- You may now receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be $5,000 or more. (See page 17.)
- You now pay 100% of the billed amount up to a maximum of $800 for anesthesia provided by a Non-participating anesthesiologist or certified registered nurse anesthetist (CRNA). Previously, you paid 25% of the Plan allowance, plus any difference between our allowance and the billed amount. [See Section 5(b).]
- Your copayment for inpatient care at Preferred hospitals is now $200 per admission. Previously, you paid $100 per admission. [See Sections 5(c) and 5(e).]
- Your copayment for ambulance transport related to a medical emergency is now $100 per day for ground ambulance transport and $150 per day for air or sea ambulance transport. Previously, you paid $50 per day for these types of services. [See Section 5(d).]

- You now pay 100% of the billed amount up to a maximum of $350 per visit for professional care provided in an emergency room by a Non-participating emergency room physician. Previously, you paid any difference between the Plan allowance and the billed amount for care related to an accidental injury, and 25% of the Plan allowance, plus any difference between our allowance and the billed amount for care related to a medical emergency. [See Section 5(d).]
- You must now obtain prior approval before receiving any outpatient Mental Health/Substance Abuse services. We no longer require a treatment plan from your provider prior to your ninth outpatient Mental Health/Substance Abuse visit. (See pages 16 and 84.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 134.)
- Your copayment for office visits to Preferred primary care professionals is now $25 per visit. Previously, you paid $20 per visit. [See Sections 5(a), 5(d), and 5(e).]
- Your copayment for outpatient facility care at Preferred hospitals is now $50 per day per facility. Previously, you paid $40 per day. [See Sections 5(c) and 5(e).]
- Your copayment for emergency room care related to an accidental injury or medical emergency is now $75 per visit. Previously, your copayment was $50 per visit. [See Section 5(d).]
- Your copayment for ambulance transport related to a medical emergency or accidental injury is now $100 per day for ground ambulance transport and $150 per day for air or sea ambulance transport. Previously, you paid $50 per day for these types of services. [See Section 5(d).]
- Your copayment for Level II formulary or preferred brand-name drugs purchased at a Preferred Retail Pharmacy is now $35 per prescription. In addition, the minimum amount you pay for Level III non-formulary or non-preferred brand-name drugs is now $45 for each 34-day supply, or $135 for a 90-day supply. Previously, you paid $30 for Level II prescriptions, and for Level III prescriptions, you paid a minimum of $35 for each purchase of a 34-day supply, or $105 for a 90-day supply. (See page 91.)

Changes to both our Standard and Basic Options

- We now provide benefits for set-up of portable X-ray equipment. Previously, benefits were not available for this service. (See page 31.)
- We now provide Preventive Care Benefits (Adult) for screening and behavioral change interventions for tobacco use and alcohol/substance abuse. Previously, Preventive Care Benefits were not available for these services. (See page 32.)
- We now provide benefits for the nonsurgical treatment of amblyopia and strabismus for children from birth through age 18. Previously, we provided benefits through age 12. (See page 42.)
- We now provide benefits for hearing aids for adults, limited to $1,000 per ear per 36-month period subject to the member cost-sharing amounts shown on page 43. Previously, benefits for adults were limited to bone anchored hearing aids.
- We now provide benefits for wigs (scalp hair prosthesis) due to hair loss due to chemotherapy for the treatment of cancer, limited to a maximum of $350 for one wig per lifetime. Previously, benefits were not available for these types of wigs. (See page 44.)
- We now provide benefits for medical foods that are administered orally and that provide the sole source (100%) of nutrition for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food. Previously, benefits were not available for these types of products. (See page 47.)
- We now provide benefits for additional types of stem cell transplants. [See Section 5(b).]
- We now provide Prescription Drug Benefits for one influenza vaccine each flu season provided by a Preferred retail pharmacy. Previously, Prescription Drug Benefits were not available for these types of vaccines. (See page 90.)
- Certain Preferred facilities have now been selected to be Blue Distinction Centers for Complex and Rare Cancers℠. More information about these centers appears on page 13.
- Chiropractors/Doctors of Chiropractic (D.C.) are now considered “other covered health care professionals.” Previously, these types of providers were listed as physicians. (See page 11.)

- You must now obtain prior approval for outpatient surgery for morbid obesity, outpatient surgical correction of congenital anomalies, and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Previously, these types of services did not require prior approval. (See page 16.)
- We clarified that benefits are not available for online medical evaluation and management services. (See page 31.)
- We clarified that we do not provide benefits for preventive medicine counseling and/or risk factor reduction intervention, interpretation of health risk assessments, or self-administered health risk assessments. (See page 32.)
- We clarified that benefits are not available for services provided by massage therapists. (See page 40.)
- We clarified that benefits are not available for orthodontic care, except for orthodontia associated with surgery to correct accidental injuries. (See page 55.)
- We clarified that benefits are not available for physician charges for shift differentials. (See page 107.)
- We clarified that benefits are not available for services performed or billed by residential therapeutic camps or for light boxes. (See pages 83 and 87.)
- We clarified the types of professional providers covered for Mental Health and Substance Abuse Care. (See pages 82 and 85.)
- We clarified that we may request medical records to support your claim for services received overseas. (See page 104.)
- We clarified that World Access Service Corporation is now Mondial Assistance. (See page 104.)

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail or internet pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 14 for the exceptions to this requirement. Refer to page 6 for more information about Preferred providers.

For Basic Option, the term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

- **Covered professional providers**

We consider the following to be covered professionals when they perform services within the scope of their license or certification:

Physicians – Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); and optometry (O.D.).

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state's applicable licensing or certification requirements and the requirements of the Local Plan. Examples of other covered health care professionals include:

- **Audiologist –** A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Chiropractor/Doctor of Chiropractic (D.C.)** – A professional who is licensed as a chiropractor by the appropriate government agency to practice chiropractic medicine where the service is performed.
- **Clinical Psychologist–** A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker–** A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator–** A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.

- **Dietician –** A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory–** A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Nurse Midwife –** A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist –** A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Nursing School Administered Clinic –** A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient "office" services rather than facility charges.
- **Nutritionist –** A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist –** A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant –** A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.
- **Otherprofessional providers** specifically shown in the benefit descriptions in Section 5.

Medically underserved areas. In the states OPM determines are "medically underserved":

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is **Preferred** for any covered service performed within the scope of that license.

For 2009, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, and Wyoming.

- **Covered facility providers**

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

- **Hospital -** An institution, or a distinct portion of an institution, that:

1. Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
2. Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
3. Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

- **Freestanding Ambulatory Facility–** A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

1. Provides services in an outpatient setting;
2. Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
3. Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
4. Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

- **Blue Distinction Centers for Bariatric Surgery, Cardiac Care, and Complex and Rare Cancers**

Certain Preferred facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, and/or Complex and Rare Cancers. These facilities meet stringent quality criteria established by expert physician panels, surgeons, and other medical professionals. The Blue Distinction Centers for Bariatric Surgery℠ provide a full range of bariatric surgical care services, including inpatient care, post-operative care, follow-up care, and patient education. The Blue Distinction Centers for Cardiac Care℠ provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization (including percutaneous coronary interventions), and cardiac surgery (including coronary artery bypass graft surgery). The Blue Distinction Centers for Complex and Rare Cancers℠ offer comprehensive inpatient cancer care programs for adults, delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise in treating complex and rare types of cancer.

If you are considering covered bariatric surgery, cardiac procedures, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. You can find these facilities listed in the online provider directory available at www.fepblue.org, or by calling the customer service number listed on the back of your ID card.

- **Blue Distinction Centers for Transplants℠**

In addition to Preferred transplant facilities, you have access to the Blue Distinction Centers for Transplants℠, a centers of excellence program. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. These facilities negotiate a payment for transplant services performed during the transplant period (see page 125 for the definition of "transplant period").

Members who choose to use a Blue Distinction Centers for Transplants facility for a covered transplant only pay the $200 per admission copayment under Standard Option, or the $100 per day copayment ($500 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services. Regular Preferred benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period.

Blue Distinction Centers for Transplants are available for eight types of transplants: heart; heart-lung; single, double, or lobar lung; liver; pancreas; simultaneous pancreas-kidney; simultaneous liver-kidney; and autologous or allogeneic bone marrow (see page 63 for limitations).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants and assistance in arranging for your transplant at a Blue Distinction Centers for Transplants facility.

- **Cancer Research Facility –** A facility that is:

1. A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
2. An NCI-designated Cancer Center; or
3. An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

- **Other facilities** specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

1. Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
2. Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
3. Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
4. Services of assistant surgeons;
5. Special provider access situations (contact your Local Plan for more information); or
6. Care received outside the United States and Puerto Rico.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for:

- **Your hospital stay**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

- You, your representative, your doctor, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission.
- If you have an **emergency admission** due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, your doctor, or your hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.

How to precertify an admission

- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended:**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor, or the hospital must ask us to approve the additional days.

- **What happens when you do not follow the precertification rules**

- If no one contacts us, we will decide whether the hospital stay was medically necessary.
- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty. [See Section 5(c) for payment information.]
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits or inpatient physician care benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and you did not get the additional days precertified, then:

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

- **Exceptions:**

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payer for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

- **Other services**

These services require prior approval under both Standard and Basic Option:

- **Outpatient surgical services –** The surgical services listed below require prior approval when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services from Preferred, Participating/Member, and Non-participating/Non-member providers. You must contact us at the customer service number listed on the back of your ID card before obtaining these types of services.
- Outpatient surgery for morbid obesity;
- Outpatient surgical correction of congenital anomalies; and

- Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.
- **Home hospice care –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved. See page 73 for information about the exception to this requirement.
- **Outpatient mental health and substance abuse treatment – You must call us** at the mental health and substance abuse number listed on the back of your ID card **before receiving any outpatient professional or outpatient facility care from Preferred providers.** We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving. For intensive outpatient treatment and partial hospitalization from Preferred providers, we will request the medical evidence we need to make our coverage determination. We will also consider the necessary duration of either of these services.
- **Organ/tissue transplants –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants –** See pages 60 and 61 for the list of conditions covered only in clinical trials for blood or marrow stem cell transplants. Contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 60 and 61, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility (see page 13) where the procedure is to be delivered.

- **Prescription drugs –** Certain prescription drugs require prior approval. Contact our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 94 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Note: Benefits for drugs to aid smoking cessation that require a prescription by Federal law are limited to one course of treatment per calendar year. Prior approval is required before benefits will be provided for additional medication. To obtain approval, the physician must certify the patient is participating in a smoking cessation program that provides clinical treatment, including counseling and behavioral therapies.

Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through an internet pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Under Standard Option, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. Medco, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Surgery by Non-participating providers under Standard Option

You may receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 16 or is one of the transplant procedures listed above) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of $20 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of $200 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is $300 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach $600.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible ($220) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only,** coinsurance does not begin until you meet your deductible.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $300 calendar year deductible.

If your provider routinely waives your cost

Note: **If your provider routinely waives** (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges $100 for a service but routinely waives your 30% Standard Option coinsurance, the actual charge is $70. We will pay $49.00 (70% of the actual charge of $70).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our **"Plan allowance"** is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. In this Plan, we have the following types of providers:

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $50 difference between our allowance and his/her bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $150 for covered services subject to a $25 copayment. Even though our allowance may be $100, you still pay just the $25 copayment. Because of the agreement, your Preferred physician will not bill you for the $125 difference between your copayment and his/her bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $150, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 30% of our $100 allowance ($30). Because of the agreement, your Participating physician will not bill you for the $50 difference between our allowance and his/her bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance –**plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see page 124). For example, you see a Non-participating physician who charges $150. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 30% of the $100 Plan allowance or $30. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

The following table illustrates examples of how much you have to pay out-of-pocket for services from a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $150 and the Plan allowance is $100. For Standard Option, the table shows the amount you pay if you have met your calendar year deductible.

Example	Preferred Physician Standard Option	Preferred Physician Basic Option	Participating physician (Standard Option*)	Non-participating physician (Standard Option*)
Physician's charge	$150	$150	$150	$150
Our allowance	We set it at: $100	We set it at: $100	We set it at: $100	We set it at: $100
We pay	85% of our allowance: $85	Our allowance less copay: $75	70% of our allowance: $70	70% of our allowance: $70
You owe: Coinsurance	15% of our allowance: $15	Not applicable	30% of our allowance: $30	30% of our allowance: $30
You owe: Copayment	Not applicable	$25	Not applicable	Not applicable
+Difference up to charge?	No: $0	No: $0	No: $0	Yes: $50
TOTAL YOU PAY	$15	$25	$30	$80

***Under Basic Option, there are no benefits for care performed by Participating and Non-participating physicians. You must use Preferred providers in order to receive benefits.** See page 14 for the exceptions to this requirement.

Note: Under Standard Option, had you not met any of your deductible in the above examples, only our allowance ($100), which you would pay in full, would count toward your deductible.

Important notice!

Preferred hospitals may contract with Non-participating providers to provide certain medical or surgical services at their facilities. Non-participating providers have no agreements with your Local Plan to limit what they can bill you. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.

Here is an example: You have coverage under Standard Option and go into a Preferred hospital for surgery. During surgery, you receive the services of a Non-participating anesthesiologist. Under Standard Option, members pay the amount billed for services provided in Preferred facilities by Non-participating anesthesiologists, up to a maximum copayment amount of $800 per anesthetist per day (no deductible or coinsurance amounts apply). For Preferred provider services, members pay only a coinsurance amount of 15% of the Preferred provider allowance after meeting the $300 calendar year deductible.

In this example, the Non-participating anesthesiologist charges $1,200 for his/her services. Our Preferred provider allowance for those services is $400. For the Non-preferred anesthesiologist's services, you would be responsible for paying the full $800 copayment amount. If you instead received services from a Preferred anesthesiologist, you would pay only 15% of the $400 allowance (after meeting your deductible), or $60, resulting in a savings to you of $740 ($800 - $60 = $740).

Always request Preferred providers for your care. Call your Local Plan at the number listed on the back of your ID card or go to our Web site, www.fepblue.org, to check the contracting status of your provider or to locate a Preferred provider near you.

- **Overseas providers.** We pay overseas claims at Preferred benefit levels, using an Overseas Fee Schedule as our Plan allowance. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care. Under Standard Option,** we pay scheduled amounts for routine dental services and you pay any balance. **Under Basic Option,** you pay $20 for any covered evaluation and we pay the balance for covered services. See Section 5(g) for a listing of covered dental services and additional payment information.
- **Hospital care.** You pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option,** you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option,** you must use **Preferred** facilities in order to receive benefits. See page 14 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for deductibles (Standard Option only), coinsurance, and copayments (other than those listed below) exceeds $7,000 under Standard Option, or $5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $5,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach $7,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 19-21;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 30% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 30% coinsurance for outpatient care by a Non-member facility;
- Under Standard Option, your $800 copayment (or the total amount you paid if less than $800) for anesthesia provided by a Non-participating anesthesiologist or certified registered nurse anesthetist (CRNA). See Section 5(b);
- Under Standard Option, your $350 per visit copayment (or the total amount you paid if less than $350) for professional care provided in an emergency room by a Non-participating emergency room physician. See Section 5(d);
- Your expenses for mental conditions and substance abuse care by a Non-preferred professional or facility provider;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-formulary brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 14 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 21 and on this page until the effective date of your new plan.

- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 21 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you . . .

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on . . .

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician . . .	Then you are responsible for . . .
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments Basic Option: your copayments and coinsurance
Participates with Medicare or accepts Medicare assignment and is **not** in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount Basic Option: all charges
Does not participate with Medicare, and is in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount Basic Option: your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount
Does not participate with Medicare and is **not** in our Preferred network	Standard Option: your deductibles, coinsurance, copayments, Basic Option: all charges

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment (see note below for Basic Option).

Note: **Under Basic Option,** you must see **Preferred** providers in order to receive benefits. See page 14 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits

See pages 9 and 10 for how our benefits changed this year. Page 132 and page 133 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things youshould keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

Each option offers unique features.

- **Standard Option** When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a $20 copayment for office visits. Standard Option also features both a Preferred retail and a Preferred mail service prescription drug program.

- **Basic Option** Basic Option does not have a calendar year deductible. Most services are subject to copayments ($25 for primary care providers and $30 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred retail pharmacy program.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option,** we provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
- **Under Basic Option,** we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers (under Basic Option) and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	**Standard Option**	**Basic Option**
Professional services of physicians and other health care professionals: • Outpatient consultations • Outpatient second surgical opinions • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(f) for prescription drug coverage] • Neurological testing ***Note:*** Please refer to page 31 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a physician, and to page 69 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.	Preferred: $20 copayment for the office visit charge (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Inpatient professional services: • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits ***Note:*** A consulting physician employed by the hospital is not the attending physician. • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(c) for our coverage of drugs you receive while in the hospital] • Neurological testing • Second surgical opinion	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**Standard Option**	**Basic Option**
• Nutritional counseling when billed by a covered provider	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Not covered : • *Routine services except for those Preventive care services described on pages 32-34* • *Online medical evaluation and management services* • *Inpatient private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by hospital rules and regulations* • *Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)]* ***Note:*** *If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**Standard Option**	**Basic Option**
Diagnostic tests provided, or ordered and billed by a physician, such as: • Blood tests • Bone density tests – screening or diagnostic • CT scans/MRIs • EKGs and EEGs • Genetic testing – diagnostic • Laboratory tests • Pathology services • Ultrasounds • Urinalysis • X-rays (including set-up of portable X-ray equipment) Diagnostic services billed by an independent laboratory	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and other diagnostic tests (cont.)	**Standard Option**	**Basic Option**
Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Preventive care, adult	**Standard Option**	**Basic Option**
Home and office visits for routine (screening) physical examinations **Under Standard Option,** benefits are limited to the following services when performed as part of a routine physical examination: • History and risk assessment • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) when performed by a Preferred provider or any independent laboratory • Screening and behavioral change interventions for tobacco use and alcohol/substance abuse ***Note:*** The benefits listed above do not apply to children up to age 22. (See benefits under *Preventive care, children*, this section.) • Chlamydial infection test **Under Basic Option,** benefits are provided for all of the services listed above and for other appropriate screening tests and services.	Preferred: $20 copayment for the examination (No deductible); nothing for services or tests ***Note:*** We provide benefits for adult routine physical examinations only when you receive these services from a **Preferred provider**. Participating: You pay all charges Non-participating: You pay all charges ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.
Not covered:	*All charges*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• *Preventive medicine counseling and/or risk factor reduction intervention, except as stated above for tobacco use and alcohol/substance abuse* • *Interpretation of health risk assessments* • *Self-administered health risk assessments*	*All charges*	*All charges*
Cancer diagnostic tests and screening procedures • Colorectal cancer tests, including: - Fecal occult blood test - Colonoscopy (see page 52 for our payment levels for diagnostic colonoscopies billed for by a physician) - Sigmoidoscopy - Double contrast barium enema • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including Pap tests) • Breast cancer tests (mammograms) Other diagnostic and screening procedures • Ultrasound for aortic abdominal aneurysm ***Note:*** Benefits are not available for genetic testing related to family history of cancer or other disease.	Preferred: $20 copayment for associated office visits (No deductible); nothing for services or tests ***Note:*** We provide benefits in full for preventive (screening) tests and immunizations only when you receive these services from a **Preferred provider** on an outpatient basis. If these services are billed separately from the routine physical examination, you may be responsible for paying an additional copayment for each office visit billed. Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.
Routine immunizations (as licensed by the U.S. Food and Drug Administration), limited to: • Hepatitis immunizations (Types A and B) for patients with increased risk or family history • Herpes Zoster (shingles) vaccines • Human Papillomavirus (HPV) vaccines • Influenza (one each flu season) and pneumococcal vaccines ***Note:*** See page 90 for our coverage of influenza (flu) vaccines provided by Preferred retail pharmacies. • Meningococcal vaccines	Preferred: $20 copayment for associated office visits (No deductible); nothing for immunizations Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment for associated office visits; nothing for immunizations Preferred specialist: $30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• Tetanus-diphtheria (Td) booster – once every 10 years	Preferred: $20 copayment for associated office visits (No deductible); nothing for immunizations Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment for associated office visits; nothing for immunizations Preferred specialist: $30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.
Not covered: Office visit charges associated with preventive services and routine immunizations performed by Participating and Non-participating providers	*All charges*	*All charges*
Preventive care, children	**Standard Option**	**Basic Option**
We provide benefits for the following services: • All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling, or adopted from outside the United States: - Routine physical examinations - Routine hearing tests - Laboratory tests - Immunizations - Human Papillomavirus (HPV) vaccines - Meningococcal vaccine - Rotavirus vaccines - Related office visits	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

Benefit Description	You Pay	
Maternity care	**Standard Option**	**Basic Option**
Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as: • Prenatal care (including ultrasound, laboratory, and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) ***Note:*** Benefits are not provided for oral tocolytic agents. Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 47. • Delivery • Postpartum care • Assistant surgeons/surgical assistance if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant	Preferred: Nothing (No deductible) ***Note:***For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers. Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance for the delivery itself and any other maternity related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services. ***Note:***For anesthesia provided by a Non-participating anesthetist, you pay 100% of the billed amount up to a maximum of $800 per anesthetist per day (no deductible).	Preferred: Nothing ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to $100 per admission. For outpatient facility services related to maternity, see pages 69-71. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 15 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary.		

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	**Standard Option**	**Basic Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. ***Note:*** When a newborn requires definitive treatment including incubation charges by reason of prematurity or evaluation for medical or surgical reasons during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits. ***Note:*** See page 52 for our payment levels for circumcision.		
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest* • *Genetic testing of the baby's father*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services, limited to: • Depo-Provera • Diaphragms and contraceptive rings • Intrauterine devices (IUDs) • Implantable contraceptives • Oral and transdermal contraceptives • Voluntary sterilization [see *Surgical procedures* in Section 5(b)] ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay $100 for related surgical procedures. See Section 5(b) for our coverage for related surgical procedures. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Contraceptive devices not describe*	*All charges*	*All charges*

Benefit Description	You Pay	
Infertility services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility, except as shown in *Not covered* ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered : • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination (AI)* - *in vitro fertilization (IVF)* - *embryo transfer and Gamete Intrafallopian Transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures, such as sperm banking*	*All charges*	*All charges*
Allergy care	**Standard Option**	**Basic Option**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit; nothing for injections Preferred specialist: $30 copayment per visit; nothing for injections Participating/Non-participating: You pay all charges (except as noted below)

Allergy care - continued on next page

Benefit Description	You Pay	
Allergy care (cont.)	**Standard Option**	**Basic Option**
		Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered: Provocative food testingand sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**Standard Option**	**Basic Option**
Outpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *How to get approval for . . .* in Section 3 (page 17). • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy ***Note:*** Home nursing visits associated with Home IV/infusion therapy are covered as shown under Home health services on page 47. • Outpatient cardiac rehabilitation ***Note:*** See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Inpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *How to get approval for . . .* in Section 3 (page 17). • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies]	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Benefit Description	You Pay	
Physical therapy, occupational therapy, speech therapy, and cognitive therapy	**Standard Option**	**Basic Option**
• Physical therapy, occupational therapy, and speech therapy when performed by a licensed therapist or physician • Cognitive rehabilitation therapy when performed by a licensed therapist or physician ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.	Preferred: $20 copayment per visit (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. ***Note:*** Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges ***Note:*** See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy (exercise on horseback)* • *Services provided by massage therapists*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
Hearing tests related to illness or injury	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies) (cont.)	**Standard Option**	**Basic Option**
		Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated under Preventive care, children)* • *Hearing aids (except as described on page 43)* • *Testing and examinations for the prescribing or fitting of hearing aids(except as needed for covered hearing aids described on page 43)*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • In lieu of surgery when the condition can be corrected by surgery, but surgery is precluded because of age or medical condition ***Note:*** Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:*** See Section 5(b), *Surgical procedures*, for coverage for surgical treatment of amblyopia and strabismus.	Preferred: $20 copayment (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 41* • *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above*	*All charges*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	**Standard Option**	**Basic Option**
• *LASIK, INTACS, radial keratotomy, and other refractive services except as described on page 41*	*All charges*	*All charges*
Foot care	**Standard Option**	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes ***Note:*** See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts. ***Note:*** See Section 5(b) for our coverage for surgical procedures.	Preferred: $20 copayment for the office visit (No deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above	*All charges*	*All charges*
Orthopedic and prosthetic devices	**Standard Option**	**Basic Option**
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Hearing aids for children up to age 22, limited to $1,000 per ear per calendar year • Hearing aids for adults age 22 and over, limited to $1,000 per ear per 36-month period ***Note:***See below for our coverage of bone anchored hearing aids. • Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to $1,000 per ear per calendar year***Note:*** Benefits for hearing aids are subject to the cost-sharing amounts shown to the right under the "You Pay" columns.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**Standard Option**	**Basic Option**
• Surgically implanted penile prostheses to treat erectile dysfunction ***Note:*** A **prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Wigs (scalp hair prosthesis) due to hair loss due to chemotherapy for the treatment of cancer ***Note:*** Benefits for wigs are paid at 100% of the billed amount, limited to $350 for one wig per lifetime.	Any amount over $350 for one wig per lifetime (No deductible)	Any amount over $350 for one wig per lifetime
Not covered: • *Shoes and over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to chemotherapy for the treatment of cancer, as stated above*	*All charges*	*All charges*
Durable medical equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• Walkers • Continuous passive motion (CPM) and dynamic orthotic cranioplasty (DOC) devices • Other items that we determine to be DME, such as compression stockings ***Note:*** We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers. ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered : • *Exercise and bathroom equipment* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps* • *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical supplies	**Standard Option**	**Basic Option**
• Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) ***Note:*** See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies • Oxygen • Blood and blood plasma, except when donated or replaced, and blood plasma expanders	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Medical supplies - continued on next page

Benefit Description	You Pay	
Medical supplies (cont.)	**Standard Option**	**Basic Option**
Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: Infant formulas used as a substitute for breastfeeding	*All charges*	*All charges*
Home health services	**Standard Option**	**Basic Option**
Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $25 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter* • *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home,* ***except*** *as included in the benefits described on page 72*	*All charges*	*All charges*
Chiropractic	**Standard Option**	**Basic Option**
• One office visit per calendar year • One set of X-rays per calendar year • Spinal manipulations ***Note:*** Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 12 for additional information.	Preferred: $20 copayment per visit (No deductible) Participating: 30% of the Plan allowance	Preferred: $25 copayment per visit ***Note:*** Benefits are limited to 20 manipulations per calendar year. Participating/Non-participating: You pay all charges

Chiropractic - continued on next page

Benefit Description	You Pay	
Chiropractic (cont.)	**Standard Option**	**Basic Option**
	Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 12 manipulations per calendar year. ***Note:*** Office visits, X-rays, and spinal manipulations that you pay for while meeting your calendar year deductible count toward the appropriate benefit limit.	
Alternative treatments	**Standard Option**	**Basic Option**
Acupuncture ***Note:*** See page 64 for our coverage of acupuncture when provided as anesthesia for covered surgery. ***Note:*** See page 35 for our coverage of acupuncture when provided as anesthesia for covered maternity care. ***Note:*** We may also cover services of certain alternative treatment providers in medically underserved areas. See page 12 for additional information.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Acupuncture must be performed and billed by a physician or licensed acupuncturist. ***Note:*** Benefits for acupuncture are limited to 24 visits per calendar year. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care physician: $25 copayment per visit Preferred physician specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. ***Note:*** Acupuncture must be performed and billed by a physician. Participating/Non-participating: You pay all charges
Not covered: • *Services you receive from noncovered providers such as:* - *naturopaths* - *hypnotherapists* • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*

Benefit Description	You Pay	
Educational classes and programs	**Standard Option**	**Basic Option**
• Smoking cessation ***Note:*** See Section 5(e) for our coverage of individual and group psychotherapy for smoking cessation and Section 5(f) for our coverage of smoking cessation drugs.	Preferred: $20 copayment for the office visit charge (No deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
• Diabetic education when billed by a covered provider ***Note:*** We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program. • Nutritional counseling for up to 4 visits per year when billed by a covered provider ***Note:*** Nutritional counseling for the treatment of anorexia and bulimia is not subject to the 4-visit limitation. ***Note:***We cover dieticians and nutritionists who bill independently for nutritional counseling.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Nutritional counseling visits (for other than anorexia and bulimia) that you pay for while meeting your calendar year deductible count toward the 4-visit limit.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation, headache, eating disorder (except as described above), and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option,** we provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
- **Under Basic Option,** we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 16 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants);** and if your surgical procedure requires an inpatient admission, **YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- Standard Option members may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be $5,000 or more. See page 17 for more information.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no deductible under Basic Option.		
Surgical procedures	**Standard Option**	**Basic Option**
A comprehensive range of services provided, or ordered and billed by a physician, such as: • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Colonoscopy – diagnostic • Other endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery* on page 54) • Treatment of burns • Circumcision of newborn • Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedic and prosthetic devices*, and Section 5(c) – *Other hospital services and supplies* – for our coverage for the device. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures • Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with co-morbidities who has failed conservative treatment; eligible members must be age 18 or over. Benefits are also available for diagnostic studies and a psychological examination performed prior to the procedure to determine if the patient is a candidate for the procedure. ***Note:*** **You must get prior approval for outpatient surgery for morbid obesity.** Please refer to page 16 for more information.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**Standard Option**	**Basic Option**
Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. ***Note:*** We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). ***Note:*** When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.		
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]* • *Cosmetic surgery* • *LASIK, INTACS, radial keratotomy, and other refractive surgery*	*All charges*	*All charges*
Reconstructive surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. ***Note:*** Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. ***Note:*** **You must get prior approval for outpatient surgical correction of congenital anomalies.** Please refer to page 16 for more information. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of the patient's breasts - treatment of any physical complications, such as lymphedemas	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**Standard Option**	**Basic Option**
Note: Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility. ***Note:*** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Surgery for placement of penile prostheses to treat erectile dysfunction	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy, except as specifically shown*	*All charges*	*All charges*
Oral and maxillofacial surgery	**Standard Option**	**Basic Option**
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth ***Note:*** **You must get prior approval for outpatient surgery needed to correct accidental injuries as described above.** Please refer to page 16 for more information. • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	**Standard Option**	**Basic Option**
• Removal of impacted teeth ***Note:*** Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g)*	*All charges*	*All charges*
Organ/tissue transplants	**Standard Option**	**Basic Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior approval procedures. ***Note:*** You must obtain prior approval (see page 17) for those transplants listed under *Prior Approval Requirements* on page 59. ***Note:*** Refer to pages 15-16 for information about precertification of inpatient care.		
Solid organ transplants are limited to: • Cornea	Preferred: 15% of the Plan allowance	Preferred: $100 copayment per performing surgeon

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Heart • Heart-lung • Kidney • Liver • Pancreas • Simultaneous pancreas-kidney • Simultaneous liver-kidney • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung • For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description. • Myeloablative allogeneic blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Chronic myelogenous leukemia - Fanconi's Anemia - Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) - High-risk neuroblastoma - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Amyloidosis - High-risk neuroblastoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Blood or marrow stem cell transplants for: • Myeloablative allogeneic blood or marrow stem cell transplants for: - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous blood or marrow stem cell transplants for: - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Germ cell tumors	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:***If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Prior approval requirements: You must obtain prior approval (see page 17) from the Local Plan, for both the procedure and the facility, for the following transplant procedures:		

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Blood or marrow stem cell transplant procedures ***Note:*** See pages 60 and 61 for services related to blood or marrow stem cell transplants covered under clinical trials. • Autologous pancreas islet cell transplant • Heart • Heart-lung • Intestinal transplants (small intestine with or without other organs) • Liver • Lung (single, double, or lobar) • Pancreas • Simultaneous liver-kidney • Simultaneous pancreas-kidney		
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or in a Blue Distinction Centers for Transplants facility in an approved clinical trial (1) For the following procedures, we provide benefits **only** when conducted at a Cancer Research Facility (see page 13) and only when performed as part of a clinical trial that meets the **requirements** listed on page 61: • Myeloablative allogeneic blood or marrow stem cell transplants for: - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma • Nonmyeloablative allogeneic blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Amyloidosis - Breast cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Colon cancer - Multiple myeloma - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
• Autologous blood or marrow stem cell transplants for: - Breast cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Epithelial ovarian cancer ***Note:*** If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the **requirements** shown below is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at a transplant facility designated by the Transplant Clinical Trials Information Unit. (2) For the following procedures we provide benefits **only** when performed in a specific NIH-sponsored, multi-center, comparative clinical trial and when the **requirements** listed below are met: • Autologous blood or marrow stem cell transplants for the following autoimmune diseases: - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis (3) **Requirements** for blood or marrow stem cell transplants covered under clinical trials: For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials: • You must contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for prior approval (see page 17);	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant • Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 57, 58, or 61 ***Note:*** Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells. • Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 57, 58, 60, or 61 • Related medical and hospital expenses of the donor, as part of a covered blood or marrow stem cell transplant procedure • Related services or supplies provided to the recipient ***Note:*** See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/Tissue Transplants at Blue Distinction Centers for Transplants

We participate in the Blue Distinction Centers for Transplants℠ program, a centers of excellence program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a Blue Distinction Centers for Transplants facility.

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous liver-kidney
- Simultaneous pancreas-kidney
- Single or double (bilateral) lung
- Lobar transplant (living donor lung)
- Blood or marrow stem cell transplants listed on pages 57, 58, 60, and 61
- Related transplant services listed on page 62

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through Blue Distinction Centers for Transplants. See page 56 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see page 13).

Note: See pages 57-61 for requirements related to blood or marrow stem cell transplant coverage.

Note: See page 13 for special instructions regarding all admissions to Blue Distinction Centers for Transplants.

Organ/tissue transplants	Standard Option	Basic Option
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, except those performed for full siblings or the unrelated actual donor* • *Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy*	*All charges*	*All charges*

Anesthesia	Standard Option	Basic Option
Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by: • a certified registered nurse anesthetist (CRNA), or • a physician other than the physician (or the assistant) performing the covered medical or surgical procedure Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. ***Note:*** See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 100% of the billed amount up to a maximum of $800 per anesthetist per day (No deductible)	Preferred: Nothing Participating/Non-participating: You pay all charges

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the **Standard Option** calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is $300 per person ($600 per family) under Standard Option.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 16 for more information.**
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your inpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.		
Inpatient hospital	**Standard Option**	**Basic Option**
Room and board, such as: • semiprivate or intensive care accommodations • general nursing care • meals and special diets	Preferred: $200 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 123 for more information.	Preferred: $200 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment ***Note:*** If you are admitted to a Non-member facility due to a **medical emergency or accidental injury**, you pay a $300 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation ***Note:*** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 15 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days.	Preferred: $200 per admission copayment for unlimited days ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered services is limited to $100 per admission. Member/Non-member: You pay all charges

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
• We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). ***Note:*** See pages 35-36 for other covered maternity services. ***Note:*** See page 47 for coverage of blood and blood products.	Preferred: $200 per admission copayment for unlimited days ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered services is limited to $100 per admission. Member/Non-member: You pay all charges
Not covered: *Hospital room and board expenses when, in our judgement, a hospital admission or portion of an admission is:* • *Custodial or long term care* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or is unsuitable* • *Not medically necessary, such as when services did not require the acute/subacute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* - *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* - *Admissions primarily for diagnostic studies, laboratory and pathology services, X-rays, MRIs, or machine diagnostic teststhat could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
Note: *If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered servicesor supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.* • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Inpatient private duty nursing*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**	**Basic Option**
Outpatient **medical services** performed and billed by a hospital or freestanding ambulatory facility, such as: • Use of special treatment rooms • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Chemotherapy and radiation therapy • Intravenous (IV)/infusion therapy • Cardiac rehabilitation • Pulmonary rehabilitation • Physical, occupational, and speech therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency medical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen ***Note:*** See pages 76-80 for our payment levels for care related to a medical emergency or accidental injury.	Preferred facilities: 15% of the Plan allowance (calendar year deductible applies) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility. Member facilities: 30% of the Plan allowance (calendar year deductible applies) Non-member facilities: 30% of the Plan allowance (calendar year deductible applies) ***Note:*** See pages 32-34 for our payment levels for covered preventive care services for adults and children. ***Note:*** See page 40 for our coverage of physical, occupational, and speech therapy.	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) ***Note:*** For outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility. ***Note:*** See page 34 for our payment levels for routine adult immunizations and preventive care services for children.
Outpatient **surgery and related services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Operating, recovery, and other treatment rooms	Preferred facilities: 15% of the Plan allowance	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Basic Option**
• Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Facility supplies for hemophilia home care • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Visits to the outpatient department of a hospital for non-emergency surgical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen ***Note:*** See page 71 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility. ***Note:*** See pages 76-80 for our payment levels for care related to a medical emergency or accidental injury. ***Note:*** We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries. We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), *Dental benefits*, for additional benefit information. ***Note:*** See pages 35-36 for other covered maternity services.	Preferred facilities: 15% of the Plan allowance ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount and pay for covered services in full when you use a Preferred facility. Member facilities: 30% of the Plan allowance Non-member facilities: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) ***Note:***F or outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:***Benefits for screening colonoscopies are subject to the cost-sharing amounts shown above. ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a hospital or freestanding ambulatory facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment	Preferred facilities: 15% of the Plan allowance (calendar year deductible applies) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.	Preferred: 30% of the Plan allowance ***Note:*** You may also be responsible for paying a $50 copayment per day per facility for outpatient services. Member/Non-member: You pay all charges

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Basic Option**
	Member facilities: 30% of the Plan allowance (calendar year deductible applies) Non-member facilities: 30% of the Plan allowance, plus any difference between our allowance and the billed amount (calendar year deductible applies)	***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**	**Basic Option**
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. ***Note:*** See page 40 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note:*** **If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.**	Preferred: Nothing Participating/Member: Nothing Non-participating/Non-member: Nothing ***Note:*** You pay all charges not paid by Medicare after the 30th day.	*All charges*

Benefit Description	You Pay	
Hospice care	**Standard Option**	**Basic Option**
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes. We provide **home hospice care** benefits for the services listed below for members with a life expectancy of six months or less **when prior approval is obtained from the Local Plan** and the home hospice agency is approved by the Local Plan. Our prior approval decision will be based upon the hospice treatment plan and clinical information provided to us. • Physician visits • Nursing care • Medical social services • Physical therapy • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)aides • Durable medical equipment rental • Prescription drugs • Medical supplies ***Note:*** We also cover pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. Prior approval is not required for these types of visits. ***Note:*** If Medicare Part A is the primary payer for your hospice care, prior approval is not required. However, our benefits will be limited to those services listed above. ***Note:*** Benefits are not available for home hospice care, e.g., care given by a home health aide, that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency.	Nothing	Nothing
Inpatient hospice for members receiving home hospice care benefits: Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. Each inpatient stay must be separated by at least 21 days. These covered inpatient hospice benefits are available only when inpatient services are necessary to:	Preferred: $200 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	**Standard Option**	**Basic Option**
• control pain and manage the patient's symptoms; or • provide an interval of relief (respite) to the family ***Note:*** **You are responsible for making sure that the home hospice care provider has received prior approval from the Local Plan** (see page 16 for instructions)**.** Please check with your Local Plan and/or your PPO directory for listings of approved agencies.	Preferred: $200 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges
Not covered: Homemaker services	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (No deductible) Participating/Member or Non-participating/Non-member: Nothing (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option does not apply. There is no calendar year deductible under Basic Option.		
Accidental injury	**Standard Option**	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** See Section 5(g) for dental benefits for accidental injuries.	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** For professional care provided in an emergency room by a Non-participating emergency room physician, your responsibility is limited to 100% of the billed amount up to a maximum of $350 per visit (No deductible). See Section 5 (b) for our coverage of surgery and anesthesia provided by Non-participating professional providers other than the emergency room physician. ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.	Preferred emergency room: $75 copayment per visit Participating/Member emergency room: $75 copayment per visit Non-participating/Non-member emergency room: $75 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $75 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $25 copayment per visit **Preferred** specialist's office: $30 copayment per visit Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges

Accidental injury - continued on next page

Benefit Description	You pay	
Accidental injury (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating* • *Emergency room physician charges for shift differentials*	*All charges*	*All charges*
Medical emergency	**Standard Option**	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** Please refer to Section 3 for information about precertifying emergency hospital admissions.	Preferred: 15% of the Plan allowance ***Note:*** If you receive services in a Preferred physician's office, you pay a $20 copayment (No deductible) for the office visit, and 15% of the Plan allowance for all other services (deductible applies). Participating/Member: 30% of the Plan allowance Non-participating/Non-member: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** For professional care provided in an emergency room by a Non-participating emergency room physician, your responsibility is limited to 100% of the billed amount up to a maximum of $350 per visit (No deductible). See Section 5 (b) for our coverage of surgery and anesthesia provided by Non-participating professional providers other than the emergency room physician. ***Note:*** These benefit levels **do not** apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on pages 76-78 for the benefits we provide.	Preferred emergency room: $75 copayment per visit Participating/Member emergency room: $75 copayment per visit Non-participating/Non-member emergency room: $75 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $75 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $25 copayment per visit **Preferred** specialist's office: $30 copayment per visit

Medical emergency - continued on next page

Benefit Description	You pay	
Medical emergency (cont.)	**Standard Option**	**Basic Option**
		Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges
Not covered: Emergency room physician charges for shift differentials	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required. ***Note:*** See Section 5(c) for non-emergency ambulance services.	Preferred: $100 copayment per day for ground ambulance transport services (No deductible) Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services (No deductible) ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day (No deductible).	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (No deductible) Participating/Member or Non-participating/Non-member: Nothing (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **YOU MUST CALL US FOR PRIOR APPROVAL BEFORE RECEIVING ANY OUTPATIENT PROFESSIONAL OR OUTPATIENT FACILITY CARE FROM PREFERRED PROVIDERS.** We will provide you with the names and phone numbers of several Preferred providers and tell you how many visits we are initially approving. You may then choose which of those providers you would like to see.
- **Under Standard Option,** the calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added "(No deductible)" to show when the deductible does not apply.
- **Under Standard Option,** there is a maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment. The first 25 visits under Standard Option each calendar year by Preferred providers and Non-preferred providers count toward this maximum. This maximum may be waived for services received from Preferred providers.
- **Under Standard Option,** you may choose to get care In-Network (Preferred) or Out-of-Network (Non-preferred). Cost-sharing and limitations for In-Network (Preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- **Under Basic Option,** there is **no calendar year deductible**.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3. Some other services also require prior approval. See the instructions after the benefits descriptions below.
- **Standard Option and Basic Option benefits** for Preferred (In-Network) mental health and substance abuse care begin below and are continued on the following pages. Standard Option benefits for Non-preferred (Out-of-Network) care begin on page 85.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preferred (In-Network) benefits	**Standard Option**	**Basic Option**
All diagnostic and treatment services for which prior approval is obtained. ***Note:*** Preferred benefits are payable only when we determine that the care is clinically appropriate to treat your condition and only when you receive the care from a Preferred provider.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Professional services, including individual or group therapy by psychiatrists, psychologists, clinical social workers, or psychiatric nurses • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation ***Note:*** Additional types of licensed providers may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.	$20 copayment for the visit (No deductible)	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay a $50 copayment for outpatient services billed for by a facility. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.
• Pharmacotherapy (medication management) • Psychological testing	Preferred: $20 copayment for the office visit charge (No deductible)	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.
• Inpatient professional visits • Professional charges for facility-based intensive outpatient treatment	15% of the Plan allowance	Nothing
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting	15% of the Plan allowance	Preferred: $30 copayment per visit
• Professional charges for outpatient diagnostic tests	15% of the Plan allowance	Nothing
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests ***Note:*** You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$200 per admission copayment (No deductible)	$100 per day copayment up to $500 per admission

Preferred (In-Network) benefits - continued on next page

Benefit Description	You Pay	
Preferred (In-Network) benefits (cont.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a hospital or other covered facility • Diagnostic tests • Services in the following approved treatment programs (must be prior approved): - partial hospitalization - facility-based intensive outpatient treatment	15% of the Plan allowance	$50 copayment per day per facility ***Note:*** For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:*** You pay 30% of the Plan allowance for drugs.
Not covered: • *Services we have not approved* • *Educational or training services* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes*	*All charges*	*All charges*

Authorization Procedures

Standard and Basic Options: To be eligible to receive Preferred mental health and substance abuse benefits, you must obtain prior approval (see below) and you must use a Preferred provider.

To locate a Preferred provider, please refer to your PPO directory, visit our Web site at www.fepblue.org, or contact us at the mental health and substance abuse phone number shown on the back of your ID card.

Precertification

You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty. Please refer to the precertification information listed in Section 3 for additional information.

Prior Approval

Standard and Basic Options: Prior approval is required for all outpatient mental health and substance abuse services.

To obtain prior approval, you, someone acting on your behalf, your physician, or your hospital must call us at the mental health and substance abuse phone number on the back of your ID card, **prior to starting treatment**. We will provide the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving. We will not provide Preferred benefits for mental health and substance abuse services, even at Preferred facilities, until you obtain prior approval.

Treatment Plans

Standard and Basic Options: In order to maximize your benefits, we may request a treatment plan from your provider.

Preferred Limitation

Under Standard Option, if you do not obtain prior approval, we will provide only Non-preferred (out-of-network) benefits.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Non-preferred (Out-of-Network) benefits	**Standard Option**	**Basic Option**
Professional services, including individual or group therapy, by psychiatrists, psychologists, clinical social workers, or psychiatric nurses. All other types of Non-preferred providers are considered noncovered. As noted on page 87, if you use the services of a noncovered provider, no benefits are available. Call the Mental Health/Substance Abuse number on the back of your ID card to locate a Preferred provider. • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation	40% of the Plan allowance for up to 25 outpatient visits per calendar year; all charges after 25 visits*. You may also be responsible for any difference between the Plan allowance and the billed amount. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Non-participating: You pay all charges
Other services: • Pharmacotherapy (medication management) • Psychological testing	30% of the Plan allowance. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Other services are not subject to the 25-visit limitation.	Participating/Non-participating: You pay all charges
Inpatient visits	40% of the Plan allowance up to 100 days per calendar year; all charges after 100 days. You may also be responsible for any difference between the Plan allowance and the billed amount.	Participating/Non-participating: You pay all charges
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$400 copayment per day (No deductible) up to 100 days per calendar year, plus any difference between our allowance and the billed amount; all charges after 100 days	Member/Non-member: You pay all charges
Outpatient services provided and billed by a hospital or other covered facility • Psychological testing	30% of the Plan allowance, plus any difference between the Plan allowance and the billed amount ***Note:*** Psychological testing is not subject to the visit limitations.	Member/Non-member: You pay all charges (except as noted below)

Non-preferred (Out-of-Network) benefits - continued on next page

Benefit Description	You Pay	
Non-preferred (Out-of-Network) benefits (cont.)	**Standard Option**	**Basic Option**
		Note: For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing.
Partial hospitalization and intensive outpatient treatment	30% of the Plan allowance, plus any difference between the Plan allowance and the billed amount; all charges after 25 visits* ***Note:*** Visits that you pay for while meeting your deductible count toward the limit cited above. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Member or Non-participating/Non-member: You pay all charges
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	Non-preferred facility: $400 copayment per day, plus any difference between our allowance and the billed amount (No deductible); all charges after 28 days per lifetime Non-preferred professional: 40% of the Plan allowance; all charges after 28 days per lifetime. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime.	Member/Non-member: You pay all charges Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services* • *Services performed by a noncovered provider*	*All charges*	*All charges*

Non-preferred (Out-of-Network) benefits - continued on next page

Benefit Description	You Pay	
Non-preferred (Out-of-Network) benefits (cont.)	**Standard Option**	**Basic Option**
• *Testing and treatment for learning disabilities and mental retardation* • *Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes*	*All charges*	*All charges*

Lifetime maximum	Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard Option**.
Precertification	You must get precertification of the medical necessity of your admission to a hospital or other covered facility. Report emergency admissions within two business days following the day of admission, even if you have been discharged. Otherwise, benefits will be reduced by $500. See Section 3 for more information on precertification.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for mental health and substance abuse benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting Non-preferred claims.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 90.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program or Mail Service Prescription Drug Program. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible**.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 94 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 94 of this Section for more information about this important program.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Under Standard Option,** PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- Please note that retail pharmacies and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. Refer to page 88 for information about locating Preferred pharmacies.
- **Under Standard Option,** you may use the Mail Service Prescription Drug Program to fill your prescriptions.
- **Under Basic Option,** the Mail Service Prescription Drug Program **is not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States or Puerto Rico, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, or through our Mail Service Prescription Drug Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, or our Mail Service Prescription Drug Program.

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through a Preferred internet pharmacy in order to receive benefits.

- **We use an open formulary.** This is a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our formulary list.

Under Standard Option, we may ask your doctor to substitute a formulary drug in order to help control costs. We cover drugs that require a prescription (whether or not they are on our formulary list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our formulary list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our formulary list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our formulary list.)

Note: Before filling your prescription, please check the formulary status of your medication. Other than changes resulting from new drugs or safety issues, the formulary list is updated once a year. Prescription drugs are reviewed by the Plan for safety and clinical efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. Using lower cost formulary drugs will provide you with a high quality, cost-effective prescription drug benefit.

Our payment levels are generally categorized as:

Level I: Includes generic drugs

Level II: Includes formulary or preferred brand-name drugs

Level III: Includes non-formulary or non-preferred brand-name drugs

You can view our formulary on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

Standard Option: By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

Basic Option: By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through a Preferred internet pharmacy, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. In most cases, they must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration (FDA) sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. However, you and your doctor have the option to request a brand-name drug even if a generic option is available. Using the most cost-effective medication saves money.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.
- **These are the dispensing limitations.**

Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

Basic Option: When you fill a prescription for the first time, you may purchase **up to** a 34-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343); or www.fepblue.org.

Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077) or www.fepblue.org.

Benefits Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Covered medications and supplies	**Standard Option**	**Basic Option**
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase ***Note:*** See Section 5(a), page 47, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube. • Insulinand and diabetic test strips • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia • Drugs to aid smoking cessation that require a prescription by Federal law ***Note:*** Prior approval is required if drug treatment extends beyond the initial course of treatment. See Section 3 for more information. • Contraceptive drugs and devices, limited to: - Depo-Provera* - Diaphragms and contraceptive rings* - Intrauterine devices (IUDs) - Implantable contraceptives* - Oral and transdermal contraceptives *available only through retail and internet pharmacies ***Note:*** See *Family planning* in Section 5(a).	See following pages	See following pages
• Influenza vaccine (one each flu season) provided by a Preferred retail pharmacy	Preferred retail pharmacy: Nothing	Preferred retail pharmacy: Nothing

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
	Non-preferred retail pharmacy: You pay all charges	Non-preferred retail pharmacy: You pay all charges
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit our Web site, www.fepblue.org, select the "Pharmacy" page, and click on the "Retail Pharmacy" link for your enrollment option (Standard or Basic) to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org ***Note:*** Please be sure to request the Preferred retail or internet pharmacy listing for your specific option. Retail and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. ***Note:*** Retail and internet pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies. ***Note:*** For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for retail pharmacy-obtained prescription drugs, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077). **For benefit information about prescription drugs supplied by Non-preferred pharmacies, please refer to the next page.**	Level I (generic drug): 20% of the Plan allowance Level II & Level III (brand-name drug): 30% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Level I (generic drug): $10 copayment Level II (formulary or preferred brand-name drug): $35 copayment Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Level I (generic drug): $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Level II (formulary or preferred brand-name drug): $35 copayment for each purchase of up to a 34-day supply ($105 copayment for 90-day supply) Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum for each purchase of up to a 34-day supply, or $135 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payer, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.	Level I (generic drug): 20% of the Plan allowance Level II & Level III (brand-name drug): 30% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Level I (generic drug): $10 copayment Level II (formulary or preferred brand-name drug): $35 copayment Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Level I (generic drug): $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Level II (formulary or preferred brand-name drug): $35 copayment for each purchase of up to a 34-day supply ($105 copayment for 90-day supply) Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum for each purchase of up to a 34-day supply, or $135 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** When a therapeutically equivalent generic product becomes available, we may classify the Level II brand-name product as a Level III brand-name drug in determining how much you pay for the drug.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
		Note: For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.
Non-preferred Retail Pharmacies	45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount ***Note:*** If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	*All charges*
Mail Service Prescription Drug Program Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. ***Note:*** Not all drugs are available through the Mail Service Prescription Drug Program.	Mail Service Program: Generic: $10 copayment per generic prescription filled (and/or refill ordered) ***Note:*** The $10 copayment amount is waived for the first 4 generic prescriptions filled (and/or refills ordered) per calendar year. Brand-name: $65 for first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; $50 per brand-name prescription/refill thereafter ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.	No benefit ***Note:*** You may request home delivery of your internet prescription drug purchases. See page 91 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
	Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, or, for Standard Option only, through the Mail Service Prescription Drug Program ***Note:*** Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. ***Note:*** For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services. • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: - Physician's office – Section 5(a) - Hospital (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 91 for retail pharmacy-obtained prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility	Preferred: 15% of the Plan allowance (calendar year deductible applies) Participating/Member: 30% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 30% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Member or Non-participating/Non-member: You pay all charges
Patient Safety and Quality Monitoring (PSQM) We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include: • Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them.		

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
• Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. • Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). **Prior Approval** As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage**. In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval. ***Note:*** If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.		
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your State law*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Note: *See Section 5(a), page 47, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Drugs for which prior approval has been denied or not obtained* • *Infant formula other than described on page 47* • *Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payer for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*,for additional information.
- **Under Standard Option,** the calendar year deductible applies only to the accidental injury benefit below. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- ***Note:*** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.

Accidental injury benefit	You Pay	
Accidental injury benefit	**Standard Option**	**Basic Option**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. ***Note:*** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. ***Note:*** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 15% of the Plan allowance (calendar year deductible applies) Participating: 30% of the Plan allowance (calendar year deductible applies) Non-participating: 30% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$25 copayment ***Note:*** **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 101.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, refer to the Preferred provider directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only		
Covered service	**We Pay**	**We Pay**	**You pay**
Clinical oral evaluations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Periodic oral evaluation*	$12	$8	
Limited oral evaluation	$14	$9	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
**Limited to two per person per calendar year*			

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
	To age 13	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
	$12	$8	
	$14	$9	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
	$14	$9	
	$14	$9	
Radiographs	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Intraoral complete series	$36	$22	
Intraoral periapical first film	$7	$5	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral periapical each additional film	$4	$3	
Intraoral occlusal film	$12	$7	
Extraoral first film	$16	$10	
Extraoral each additional film	$6	$4	
Bitewing – single film	$9	$6	
Bitewings – two films	$14	$9	
Bitewings – four films	$19	$12	
Bitewings – vertical	$12	$7	
Posterior-anterior or lateral skull and facial bone survey film	$45	$28	
Panoramic film	$36	$23	
Tests and laboratory exams	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Pulp vitality tests	$11	$7	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Palliative treatment	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Palliative (emergency) treatment of dental pain – minor procedure	$24	$15	
Sedative filling	$24	$15	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
			Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Preventive	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Prophylaxis – adult*	---	$16	
Prophylaxis – child*	$22	$14	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Topical application of fluoride (prophylaxis not included) – child	$13	$8	
Topical application of fluoride (prophylaxis not included) – adult	---	$8	
**Limited to two per person per calendar year*			
Space maintenance (passive appliances)	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Space maintainer – fixed – unilateral	$94	$59	
Space maintainer – fixed – bilateral	$139	$87	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Space maintainer – removable – unilateral	$94	$59	
Space maintainer – removable – bilateral	$139	$87	
Recementation of space maintainer	$22	$14	
Amalgam restorations (including polishing)	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Amalgam – one surface, primary or permanent	$25	$16	
Amalgam – two surfaces, primary or permanent	$37	$23	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Amalgam – three surfaces, primary or permanent	$50	$31	
Amalgam – four or more surfaces, primary or permanent	$56	$35	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
Filled or unfilled resin restorations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Resin – one surface, anterior	$25	$16	
Resin – two surfaces, anterior	$37	$23	
Resin – three surfaces, anterior	$50	$31	
Resin – four or more surfaces or involving incisal angle (anterior)	$56	$35	
Resin-based composite – one surface, posterior	$25	$16	
Resin-based composite – two surfaces, posterior	$37	$23	
Resin-based composite – three surfaces, posterior	$50	$31	
Resin-based composite – four or more surfaces, posterior	$50	$31	
Inlay restorations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Inlay – metallic – one surface	$25	$16	
Inlay – metallic – two surfaces	$37	$23	
Inlay – metallic – three or more surfaces	$50	$31	
Inlay – porcelain/ceramic – one surface	$25	$16	
Inlay – porcelain/ceramic – two surfaces	$37	$23	
Inlay – porcelain/ceramic – three or more surfaces	$50	$31	
Inlay – composite/resin – one surface	$25	$16	
Inlay – composite/resin – two surfaces	$37	$23	
Inlay – composite/resin – three or more surfaces	$50	$31	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
Other restorative services	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Pin retention – per tooth, in addition to restoration	$13	$8	*Note:* For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Extractions – includes local anesthesia and routine post-operative care			
Extraction, erupted tooth or exposed root	$30	$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27	
Surgical removal of residual tooth roots (cutting procedure)	$71	$45	
General anesthesia in connection with covered extractions	$43	$27	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $20 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, please refer to the Preferred provider directory, visit our Web site at ww.fepblue.org, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
Covered service	**We Pay**	**You Pay**
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Radiographs Intraoral – complete series including bitewings (*limited to 1 complete series every 3 years*) Bitewing – single film* Bitewings – two films*	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges

Covered service - continued on next page

Basic Option dental benefits	Basic Option Only	
Covered service (cont.)	**We Pay**	**You Pay**
Bitewings – four films* *Benefits are limited to a combined total of 4 films per person per calendar year	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Preventive Prophylaxis – adult *(up to 2 per calendar year)* Prophylaxis – child *(up to 2 per calendar year)** Topical application of fluoride (prophylaxis not included) – child *(up to 2 per calendar year)* Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Special features

Special feature	Description
Flexible benefits option	Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a **flexible benefits option**. This option allows nurse case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an **alternative benefits agreement** that includes the terms listed below. • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we cannot guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the **alternative benefits agreement**, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. If you sign the **alternative benefits agreement**, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written **alternative benefits agreement** must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply.
Visit our new Web site!	We are pleased to announce that we have enhanced our Web site – www.fepblue.org – to better serve the health care needs of our Service Benefit Plan members. Now you can use the site to manage your health and your health care benefits with ease. Whether it's comparing benefit plans, choosing the coverage that best meets the needs of you and your family, or locating a provider near your home, www.fepblue.org allows you to understand your options and make informed decisions. Click on the new "My Blue" section to easily access a wide range of services such as checking the status of your claims, requesting claim forms, ordering a duplicate or replacement Service Benefit Plan ID card, changing your address of record, or finding the telephone number to talk to one of our customer service representatives. Visit the new health and wellness section for valuable information about healthy behaviors and lifestyles. The new www.fepblue.org is designed to give you quick access to the information you're looking for so that you can more easily understand and manage your health care benefits and your health care needs. That's why you'll find new search tools and easy-to-use features like the ability to increase text size at the touch of a button, print pages quickly, and e-mail Web site content. We hope you visit the new www.fepblue.org and take advantage of its many resources!

Special feature	Description
Blue Health Connection	Stay connected to your health and get the answers you need when you need them by using Blue Health Connection 24 hours a day, 365 days a year. This service offers you direct communication with a Registered Nurse by calling 1-888-258-3432 toll-free, or by accessing our Web site, www.fepblue.org. Blue Health Connection provides one-stop shopping for health information and health care management. You can check your symptoms with the Symptoms Checker, read information about healthy eating and weight loss, and listen to a range of health-related topics from the AudioHealth Library. In addition, you can complete a quick online Health Assessment that will help you look at your personal health, review your family history, and obtain personalized suggestions about health-related behaviors to improve or maintain your health and wellness. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site, www.fepblue.org, adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease. Select the "Web Accessibility" link and take advantage of special captioning, audio descriptions, screen reader optimization, enlarged text options, and high color contrast for enhanced visibility.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States and Puerto Rico.
Health support programs	The Service Benefit Plan offers patient education and support programs for certain diagnoses in select locations. Call the customer service number on the back of your ID card to find out what programs are available in your area.
Healthy Families Program	Healthy Families is a national health education prevention program that provides educational mailings to members and their families to help adopt healthy behaviors, reduce risk of injury and disease, and improve existing chronic conditions.
***WalkingWorks®* Wellness Program**	*WalkingWorks®* can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online *WalkingWorks* tracking tool. Log in at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. *WalkingWorks* was developed in cooperation with the President's Council on Physical Fitness and Sports.

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. See below and page 105 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For professional care you receive overseas, we provide benefits at Preferred benefit levels using an Overseas Fee Schedule as our Plan allowance. **Under Standard Option,** you must pay any difference between our payment and the amount billed, in addition to any applicable deductible, coinsurance, and/or copayment amounts. You must also pay any charges for noncovered services.

Under Basic Option, you pay any difference between our payment and the amount billed, as well as the applicable copayment or coinsurance. You must also pay any charges for noncovered services. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States and Puerto Rico.**

For facility care you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 69-71.

For dental care you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option,** you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option,** you must pay the $20 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. The Worldwide Assistance Center can help you locate a hospital in our network near where you are staying. You may also view a list of our network hospitals on our Web site, www.fepblue.org. Although we do not have a network of professionals overseas, the Worldwide Assistance Center can also help you locate a physician. You will have to file a claim to us for reimbursement for professional services.

If you are overseas and need assistance locating providers, contact the Worldwide Assistance Center (provided by Mondial Assistance – formerly World Access Service Corporation), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the Virgin Islands should call 1-800-699-4337. Mondial Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States and Puerto Rico, send a completed Overseas Claim Form and itemized bills to: Mailroom Administrator, FEP Overseas Claims, P.O. Box 14133, Lexington, KY 40512-4113. We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to this address or call us at 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. You may also obtain Overseas Claim Forms from this address, from our Web site (www.fepblue.org), or from your Local Plan.

Filing overseas claims

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States and Puerto Rico, send a completed FEP Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

Please note that under both **Standard and Basic Options**, you may fill your prescriptions through a Preferred internet pharmacy only if the prescribing physician is licensed in the United States or Puerto Rico.

Under Standard Option, you may order your prescription drugs from the Mail Service Prescription Drug Program only if:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U. S. territories) and
- The prescribing physician is licensed in the United States or Puerto Rico.

Please see page 92 for more information about using this program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim for

these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines.

For additional information, contact us at the phone number on the back of your ID card or visit our Web site at www.fepblue.org.

Discount Drug Program
The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, and Viagra tablet;
For weight loss: Meridia capsule and Xenical capsule;
For hair removal: Vaniqa cream;
For hair growth: Propecia; and
For pigmenting/depigmenting: Alustra, Benoquin, Eldoquin, Epiquin Micro, Solaquin, Tretinoin, and Tri-Luma.

Drugs may be added to this list as they are approved by the Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Federal DentalBlue
Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. To apply for Federal DentalBlue, you must be:

1.1. Enrolled in Standard Option and reside in one of the following Plan areas: Alabama, Illinois, New Mexico, Oklahoma, Texas, or in the counties of Clallam, Columbia, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, or Yakima in Washington State; or

2.2. Enrolled in Basic Option and reside in one of the following Plan areas: Alabama, Illinois, New Mexico, Oklahoma, or Texas.

To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your local Blue Cross and Blue Shield Plan. For more information on Federal DentalBlue, please contact us at:
Alabama: 1-800-492-8872 or www.bcbsal.org
Illinois: 1-866-431-1595 or www.yourfederaldental.com
New Mexico: 1-866-431-1604 or www.yourfederaldental.com
Oklahoma: 1-866-431-1602 or www.yourfederaldental.com
Texas: 1-866-431-1598 or www.yourfederaldental.com
Washington State Counties: 1-888-224-4366

Vision Care Affinity Program
Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to over 27,000 providers including optometrists, ophthalmologists, and many retail centers. For a complete description of the program or to find a provider near you, visit us at www.fepblue.org or call **1-800-551-3337**between 8:00 a.m. and 11:00 p.m. eastern time, M-F;

9:00 a.m. to 4:00 p.m. on Sat.; and noon to 4:00 p.m. on Sun. Members can save on replacement contact lenses by visiting www.lens123.com or calling 1-800-536-7123. Members can also save up to 25% off the **provider's usual fee**, or 5% off sales pricing, on laser vision correction procedures. Call **1-800-551-3337**for the nearest location and authorization for the discount.

Medicare Advantage Plan Enrollment
Some local Blue Cross and Blue Shield Plans offer Medicare recipients the opportunity to enroll in a Medicare Advantage plan without payment of an FEHB premium. Contact your local Blue Cross and Blue Shield Plan for more information.

SNAPforSeniors®
SNAPforSeniors® (**S**earch **N**ew **A**vailable **P**laces) simplifies the difficult process of finding appropriate senior housing options by providing members with the Senior Housing Locator – an online tool to access a current, comprehensive database of more than 60,000 senior housing communities. By using the Senior Housing Locator, you can search for assisted living communities, residential care, nursing homes, continuing care retirement communities, and independent living communities anywhere in the nation. You can personalize your housing choices to best match the services and amenities available in each community to your lifestyle and health needs. The Senior Housing Locator can be accessed via www.fepblue.org.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants)**.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction);
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program;
- Services, drugs, or supplies you would not be charged for if you had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service;
- Amounts charged that neither you nor we are legally obligated to pay, such as amounts over the Medicare limiting charge or equivalent Medicare amount as described in Section 4 under *Your costs for covered services*, or State premium taxes, however applied;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption;
- Services or supplies (except for medically necessary prescription drugs) that you receive from a noncovered facility, such as an extended care facility or nursing home, except as specifically described in Sections 5(a) and 5(c);
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 12;
- Services, drugs, or supplies you receive for cosmetic purposes;
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of morbid obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures (see page 52); and, those nutritional counseling services specifically listed on pages 30, 50, and 67;
- Services you receive from a provider that are outside the scope of the provider's licensure or certification;
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*;
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome;
- Services of standby physicians;
- Self-care or self-help training;
- Custodial care;
- Personal comfort items such as beauty and barber services, radio, television, or telephone;
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs;

- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c) and screenings specifically listed on pages 32-34;
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay;
- Topical Hyperbaric Oxygen Therapy (THBO);
- Physician charges for shift differentials; or
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note:Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) form you received from any primary payer [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, home nursing care, and physical, occupational, and speech therapy, require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, or through the Mail Service Prescription Drug Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See below for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, and the Mail Service Prescription Drug Program.)

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our Web site, www.fepblue.org, visit the "Pharmacy" page, and click on the "Retail Pharmacy" link for your enrollment option (Standard or Basic) to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 17).

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail or internet pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail or internet pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

(1) Complete the initial mail order form;

(2) Enclose your prescription and copayment;

(3) Mail your order to Medco, P.O. Box 30496, Tampa, FL 33633-1524; and

(4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890

(TDD: 1-800-216-5343). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 104 and 105 of this brochure.

When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification or prior approval required by Section 3:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or b) Write to you and maintain our denial – go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 1, 1900 E Street, NW, Washington, DC 20415-3610. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and

- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We have not responded yet to your initial claim or request for precertification/prior approval, then call us at the customer service number on the back of your Service Benefit Plan ID card and we will expedite our review; or

b) We denied your initial claim or request for precertification/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 1 at 1-202-606-0727 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payer's benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payer.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 116.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 23 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 16 for exception).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-admission copayments;
  - Inpatient Non-member hospital coinsurance; and
  - Non-preferred inpatient per-day copayments for mental conditions/substance abuse care.
- Under **Basic Option**, we will waive our:
  - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
  - Copayments for office visits to Preferred physicians and other health care professionals;
  - Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
  - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

  A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

  Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 14 for the exceptions to this requirement.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

  This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
	The primary payer for the individual with Medicare is...	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we provide benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representativesobtain (whether by lawsuit, settlement, insurance or benefit program claims, orotherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include,if applicable, your heirs, administrators, legal representatives, parents (if you are a minor),successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

- We will not reduce our share of any recovery unless,in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - Uninsured and underinsured motorist coverage
  - Workers' Compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10. Definitions of terms we use in this brochure

Accidental injury An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. ***Note:*** Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.

Admission The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.

Assignment An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.

Calendar year January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Carrier The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Case management A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2002). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and is accredited by URAC. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 18.

Copayment A copayment is a fixed amount of money you pay when you receive covered services. See page 18.

Cosmetic surgery Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services Services we provide benefits for, as described in this brochure.

Custodial care Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or

6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as Long Term Care. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 18.

Durable medical equipment

Equipment and supplies that:

1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished. ***Note:*** Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only:

- published reports and articles in the authoritative medical and scientific literature;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Each Local Plan has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

For more detailed information, contact your Local Plan at the customer service telephone number located on the back of your Service Benefit Plan ID card.

Group health coverage Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Intensive outpatient care A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Lifetime maximum The maximum amount the Plan will pay on your behalf for covered services you receive while you are enrolled in your option. Benefit amounts accrued are accumulated in a permanent record regardless of the number of enrollment changes. Please see page 87.

Local Plan A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical foods The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;
3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Mental conditions/ substance abuse Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Partial hospitalization An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base our payment, and your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers -** Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail and internet pharmacies that contract with Caremark) have agreed to accept as payment in full, when we pay primary benefits.

Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 97 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers -** Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Non-participating providers -** We have no agreements with these providers. We determine our allowance as follows:
  - For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;
  - For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is the average amount for all outpatient surgical claims that we pay nationally to contracting and non-contracting facilities. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury, our allowance is the billed amount (minus any amounts for noncovered services);

- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the 2009 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");
- For prescription drugs furnished by retail and internet pharmacies that do not contract with Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth in the most current version of First DataBank's National Drug Data File; and
- For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with Mondial Assistance, our allowance is an Overseas Fee Schedule that is based on amounts comparable to what Participating providers in the Washington, DC, area have agreed to accept.

Non-participating providers are under no obligation to accept our allowance as payment in full. If you use Non-participating providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances – see below). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment amounts.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than $5,000 for an episode of care, your responsibility will be limited to $5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive duringan emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services),plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as aradiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, orpediatric sub-specialist;and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providersin a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 77 and 79).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 21, 104, and 105.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail and internet pharmacies, between pharmacies and Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed;
2. The Retail Pharmacy Program (for prescription drugs and supplies purchased through Preferred retail and internet pharmacies) or the Mail Service Prescription Drug Program; or
3. The Blue Cross and Blue Shield Association Clinical Trials Information Unit for certain organ/tissue transplants we cover only in clinical trials. See Section 5(b).

For more information, see the benefit descriptions in Section 5 and *How to get approval for . . . Other services* on pages 16-17. See Section 5(e) for special authorization requirements for mental health and substance abuse benefits.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Transplant period

A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Us/We/Our

"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide toFederal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next Open Season for enrollment begins.

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide toFederal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide toFederal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

  You may convert to a non-FEHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

  The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

  For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA. .

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

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Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2009

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $300 per person ($600 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: 15%* of our allowance; $20 per office visit Non-PPO: 30%* of our allowance	29-31
Services provided by a hospital:		
• Inpatient	PPO: $200 per admission Non-PPO: $300 per admission	66-68
• Outpatient	PPO: 15%* of our allowance (no deductible for surgery) Non-PPO: 30%* of our allowance (no deductible for surgery)	69-71
Emergency benefits:		
• Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	76-78
• Medical emergency	Regular benefits for physician and hospital care* Ambulance transport services: $100 per day for ground ambulance (no deductible); $150 per day for air or sea ambulance (no deductible)	76, 79-80
Mental health and substance abuse treatment	In-Network (PPO): Regular cost-sharing, such as $20 office visit copay (prior approval required); $200 per inpatient admission Out-of-Network (Non-PPO): Benefits are limited	81-87
Prescription drugs	Retail Pharmacy Program: • PPO: 20% of our allowance generic/30% of our allowance brand-name; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program:	88-95

	• $10 generic/$65 brand-name per prescription; up to a 90-day supply	
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	55, 96--100
Special features:	**Special features:** Flexible benefits option; online customer and claims service; Blue Health Connection; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; Healthy Families Program; and *WalkingWorks®* Wellness Program	102-103
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 (PPO) or $7,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	21-22

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2009

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 14. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $25 per office visit for primary care physicians and other health care professionals; $30 per office visit for specialists Non-PPO: You pay all charges	29-31
Services provided by a hospital:		
• Inpatient	PPO: $100 per day up to $500 per admission Non-PPO: You pay all charges	66-68
• Outpatient	PPO: $50 per day per facility Non-PPO: You pay all charges	69-71
Emergency benefits:		
• Accidental injury	PPO: $75 copayment for emergency room care; $30 copayment for urgent care Non-PPO: $75 copayment for emergency room care Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	76-78
• Medical emergency	Same as for accidental injury	76, 79-80
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $25 office visit copayment (prior approval required); $100 per day up to $500 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	81-87
Prescription drugs:	Retail Pharmacy Program: • PPO: $10 generic/$35 formulary brand-name per prescription/50% coinsurance ($45 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges	88-95

Basic Option Benefits	You pay	Page
Dental care	PPO: $20 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	55, 96-97, 101
Special features:	**Special features:** Flexible benefits option; online customer and claims service; Blue Health Connection; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; Healthy Families Program; and *WalkingWorks®* Wellness Program	102-103
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000 (PPO) per contract per year; some costs do not count toward this protection	21-22

2009 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the *Guide to Benefits for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees, and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Standard Option Self Only	104	$155.66	$70.18	$337.26	$152.06	$179.45	$46.39
Standard Option Self and Family	105	$352.56	$164.58	$763.88	$356.59	$406.42	$110.72
Basic Option Self Only	111	$128.00	$42.66	$277.32	$92.44	$147.62	$23.04
Basic Option Self and Family	112	$299.75	$99.91	$649.45	$216.48	$345.71	$53.95

HEALTH BENEFIT BOOKLET

BLUE ACCESS PPO

STATE OF INDIANA

Anthem Traditional Plan II ASO

Administered by Anthem Insurance Companies, Inc.

Anthem Insurance Companies, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

INTRODUCTION

This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your health benefits. This document replaces and supersedes any Benefit Booklet or summary that you have received previously. Please read this Benefit Booklet carefully, and refer to it whenever you require medical services.

This Benefit Booklet describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Benefit Booklet are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Benefit Booklet.

The coverage described in this Benefit Booklet is based upon the conditions of the Administrative Services Agreement issued to your Employer, and is based upon the benefit plan that your Employer chose for you. The Administrative Services Agreement, this Benefit Booklet and any endorsements, amendments or riders attached, form the Administrative Services Agreement under which Covered Services are available under your health care benefits.

Many words used in this Benefit Booklet have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these Definitions for the best understanding of what is being stated.

If you have any questions about this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com.

/s/

President

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

- Receive information about the organization and its services, practitioners and Providers, and Members' rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under the Plan;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under the Plan;
- Participate with your Provider in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services you received from a Provider, or the service you received from the Administrator, and to have the Administrator, on behalf of the Employer, investigate and take appropriate action;
- File a complaint with the Administrator, on behalf of the Employer, to Appeal that decision as outlined in the **Member Grievance** section of this Benefit Booklet, and to Appeal a decision to the Department of Insurance without fear of reprisal;
- Privacy and confidential handling of your information;
- Make recommendations regarding the Administrator's rights and responsibilities policies; and
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Member, You Have the Responsibility to:

- Understand your health issues and be wise consumers of health care services;
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information the Administrator needs to administer benefits and that Providers need to care for you;
- Follow the plan and instructions for care that you and your Provider have developed and agreed upon;
- Understand how to access care in routine, Emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Coinsurance, Copayments, etc.;
- Notify your Provider or the Administrator about concerns you have regarding the services or medical care you receive;

- Keep appointments for care and give reasonable notice of cancellations;
- Be considerate of other Members, Providers and the Administrator's staff;
- Read and understand your Benefit Booklet and Schedule of Benefits, and other materials from the Administrator or Employer concerning your health benefits;
- Provide accurate and complete information to the Administrator, on behalf of the Employer, about other health care coverage and/or insurance benefits you may carry; and
- Inform the Administrator and the Employer, of changes to your name, address, phone number, or if you want to add or remove Dependents.

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SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Member's responsibility for Covered Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and **non Covered** charges.

Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

BENEFIT PERIOD	Calendar Year
DEPENDENT AGE LIMIT	To the end of the calendar year in which the child attains age 19; or to the end of the calendar year in which the child attains age 23 if the child is a full-time student at an educational institution. For additional Dependent Information such as Disabled Dependent eligibility, see the Eligibility and Enrollment section of this Benefit Booklet.

DEDUCTIBLE	**Network**	**Non-Network**
Per Member (Single Coverage)	$500	$500
Per Family	$500	$500
	OR	
[*Tobacco Incentive-* Per Member (Single Coverage)	$0	$0
Per Family	$0	$0]

NOTE: The Deductible applies to all Covered Services with a Coinsurance amount. The Deductible, if applicable, must be satisfied before any Covered Services are paid by the Plan except for services with no Copayments/Coinsurance.

OUT-OF-POCKET LIMIT	Network	Non-Network
Per Member (Single Coverage)	$2,000	$2,000
Per Family	$4,000	$4,000

NOTE: The Out-of-Pocket Limit includes all Deductibles, Copayments and Coinsurance amounts you incur in a Benefit Period except for the following services:

- Prescription Drug benefits
- Non-Network Human Organ and Tissue Transplant services.

Once the Member and/or family Out-of- Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for the services listed above.

Network and Non-Network Copayments and Coinsurance are separate and do not accumulate toward each other. Network and Non-Network Out-of-Pocket Limits are NOT separate and DO accumulate toward each other.

LIFETIME MAXIMUMS	Network	Non-Network
Morbid Obesity Surgical Treatment Maximum	Unlimited (Network and Non-Network combined)	
TMJ Services Lifetime Maximum	$2,500 (Network and Non-Network Combined) per Member	
Lifetime Maximum for all other Covered Services	$2,000,000 (Network and Non-Network combined) per Member	

NOTE: While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

COVERED SERVICES	COPAYMENTS/COINSURANCE/MAXIMUMS	
	Network	**Non-Network**
Ambulance Services	$50 Copayment	$50 Copayment
Behavioral Health Services Coverage for the Inpatient and Outpatient treatment of Behavioral Health is provided to the same extent and degree as for the treatment of physical illness.		
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia)	Copayments/Coinsurance based on setting where Covered Services are received	40% Coinsurance
Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and/or tests, including services received at an independent Network lab, may not require a Copayment/ Coinsurance. Laboratory services provided by a facility participating in the Administrator's Laboratory Network (as shown in the Provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of the Administrator's Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.	
NOTE: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received are subject to the Other Outpatient Services Copayment/ Coinsurance regardless of setting where Covered Services are received		
Emergency Room Services (Copayment/Coinsurance is waived if you are admitted)	$75 Copayment per visit	$75 Copayment per visit
Home Care Services	$20 Copayment per day	40% Coinsurance
Maximum visits per Benefit Period	Unlimited (Network and Non-Network combined)	

NOTE: Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.

Private Duty Nursing Lifetime Maximum	$5,000 per Member

Hospice Services	20% Coinsurance	20% Coinsurance
Inpatient and Outpatient Professional Services	No Copayment/Coinsurance up to the Maximum Allowable Amount	40% Coinsurance
Inpatient Facility Services	$500 Copayment per admission	40% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	Unlimited (Network and Non-Network combined)	
Maternity Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non- Network Pharmacy.)	20% Coinsurance	40% Coinsurance
Maximum per Benefit Period for Prosthetic devices received on an Outpatient basis (does not include surgical prosthetics or prosthetic limbs)	Unlimited (Network and Non-Network combined)	

Maximum per Benefit Period for all Durable Medical Equipment and Orthotics (does not include Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb)	Unlimited (Network and Non-Network combined)
Lifetime Maximum for Prosthetic limbs (includes an orthotic custom fabricates brace or support designed as a component for a Prosthetic limb)	Unlimited (Network and Non-Network combined)

NOTE: Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan. They are also subject to a separate lifetime maximum and do not apply to the Plan Lifetime Maximum.

NOTE: If Durable Medical Equipment or appliances are obtained through your PCP/SCP or another Network Physician's office, Urgent Care Center Services, Other Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/ Coinsurance in the setting where Covered Services are received.

Outpatient Services		
Other Outpatient Services	No Copayment/Coinsurance up to the Maximum Allowable Amount	40% Coinsurance

Note: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received

Outpatient Surgery Hospital/Alternative Care Facility	$250 Copayment per visit	40% Coinsurance

Physician Home Visits and Office Services		
Primary Care Physician (PCP)	$20 Copayment per visit	40% Coinsurance

This Copayment/Coinsurance also applies to the following Covered Services regardless of Outpatient setting where they are received: • Routine and Diagnostic Mammograms • Diabetes self management training • Medical Nutritional therapy (Network only)		
Specialty Care Physician (SCP)	$20 Copayment per visit	40% Coinsurance
Allergy Injections	$5 Copayment per visit	40% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician's office are subject to the Other Outpatient Services Copayment/Coinsurance

The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Surgical Services	No Copayments/Coinsurance up to the Maximum Allowable Amount	40% Coinsurance
Temporomandibular Joint (TMJ) Services (surgical and non-surgical)	Copayments/Coinsurance based on setting where Covered Services are received	40% Coinsurance

Therapy Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received

NOTE: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation

Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

Maximum Visits per Benefit period for:

Physical Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Occupational Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Speech Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Manipulation Therapy	12 visits, combined Network and Non-Network.

Urgent Care Center Services	$35 Copayment per visit	$35 Copayment per visit. You are responsible for any amounts that exceed the Maximum Allowable Amount.

Human Organ and Tissue Transplant Services

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Member cost shares.

Transplant Benefit Period	Network Transplant Provider	Non-Network Transplant Provider
	Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34-50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility	The later of 30 days or date of discharge following a Covered Transplant Procedure at a Non-Network Transplant Provider Facility.

Deductible	Network Transplant Provider	Non-Network Transplant Provider
	Not Applicable	Applicable during the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.

Covered Transplant Procedure during the Transplant Benefit Period	Network Transplant Provider	Non-Network Transplant Provider
	Copayment/Coinsurance based on place of setting, subject to the $2,000 Out-of-Pocket Limit. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	During the Transplant Benefit Period, You will pay 40% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also a Network Provider for this Certificate (for services other than Transplant Services and Procedures), then you will not be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. If the Provider is a Non-Network

		Provider for this Certificate, you **will** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Service, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**	**Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**
	Copayment/Coinsurance based on place of setting, subject to the $2,000 Out-of-Pocket Limit.	Not Covered for Transplants received at a Non-Network Transplant Provider Facility
Transportation Lodging and Meals	Covered, as approved by the Plan, up to a $10,000 benefit limit.	You are responsible for 40% of Maximum Allowable Amount after the Deductible has been met.
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved by the Plan, up to a $30,000 benefit limit.	Covered as approved by the Plan, up to a $30,000 benefit limit. You will be responsible for 40% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.
Live Donor Health Services	Covered as determined by the Plan.	You will pay 40% of the Plan's Maximum Allowable Amount for Medically Necessary live organ donor expenses. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

Prescription Drugs

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Retail Pharmacy (Network and Non-Network)	34 days or 100 units of medication (whichever is greater)
Mail Service	90 days
Retail Specialty Pharmacy (Network and Non-Network) and Specialty Mail Service	34 days or 100 units of medication (whichever is greater)

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance

Tier 1 Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Prescription Drugs	$20 Copayment per Prescription Order
Tier 3 Prescription Drugs	40% Coinsurance(minimum $40 & maximum $100) per Prescription Order
Tier 4 Prescription Drugs	40% Coinsurance(minimum $40 & maximum $100) per Prescription Order

Anthem's Network Mail Service Program Prescription Drug Company/Coinsurance:

Tier 1 Prescription Drugs	$20 Copayment per Prescription Order
Tier 2 Prescription Drugs	$40 Copayment per Prescription Order
Tier 3 Prescription Drugs	40% Coinsurance(minimum $80 & maximum $150) per Prescription Order
Tier 4 Prescription Drugs	40% Coinsurance(minimum $80 & maximum $150) per Prescription Order

Specialty Network Retail Including Specialty Mail Service Program Prescription Drug Copayment/Coinsurance:

Tier 1 Specialty Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Specialty Prescription Drugs	$20 Copayment per Prescription Order
Tier 3 Specialty Prescription Drugs	40% Coinsurance(minimum $40 & maximum $100) per Prescription Order

Tier 4 Specialty Prescription Drugs	40% Coinsurance(minimum $40 & maximum $100) per Prescription Order
Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Copayment/Coinsurance:	40% Coinsurance per Prescription Order

NOTE: No Copayment/Coinsurance applies to certain Diabetic and asthmatic supplies, up to the Plan's Maximum Allowable Amount, when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies, Durable Medical Equipment, and Appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayments/Coinsurance.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **For most services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider to be a Covered Service, except for Emergency Care and Urgent Care. Services which are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care and Urgent Care.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. The Administrator cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Plan, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Administrator bases its' decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's clinical coverage guidelines and medical policy. The Administrator may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. The Plan's payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period Limit/Maximum, or Lifetime Maximum in this Benefit Booklet.**

Ambulance Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

Other vehicles which do not meet this definition, including but not limited to ambulettes, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by The Plan to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

- **Partial hospitalization** - an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

- **Intensive Outpatient treatment or day treatment** - a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.

- **Outpatient treatment, or individual or group treatment** - office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family-therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

To assist you in obtaining appropriate and quality care, the Administrator will ask your Provider to submit a treatment plan after you have been evaluated after 10 Outpatient visits. The Administrator may discuss the goals of treatment and changes in the treatment plan, including alternative courses of treatment, with your Provider in order to manage your benefits effectively and efficiently.

Non Covered Behavioral Health Services (please also see the Exclusions section of this Benefit Booklet for other non Covered Services)

- Custodial or Domiciliary Care.
- Supervised living or halfway houses.
- Services or care provided or billed by a residential treatment center, school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

- Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.

Coinsurance, Copayments and limits are specified in the Schedule of Benefits.

Dental Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member who is physically or mentally disabled, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is

necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Diagnostic Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use the Administrator's independent laboratory Network Provider called the Reference Laboratory Network (RLN).

When Diagnostic services are performed within 3 days (72 hours) as part of pre-admission testing required for an Inpatient admission or an Outpatient surgery, no Copayment is required. Any Coinsurance will still apply.

When Diagnostic radiology is performed in a Network Physician's Office, no Copayment is required. Any Coinsurance from a Network or a Non-Network Physician will still apply.

Emergency Care and Urgent Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Medically Necessary services which the Administrator determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. In certain circumstances, Emergency Care received from a Non-Network Provider may be approved as an Authorized Service. You must contact the Administrator for authorization prior to the claim being filed. In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Administrator, on behalf of the Employer, or verify that your Physician has notified the Administrator of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with the Administrator or is a BlueCard Provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determines is not Medically Necessary.

The Behavioral Health Services Subcontractor also must be notified of all Emergency admissions for Behavorial Health services within 48 hours after admission or as soon as possible within a reasonable period of time.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network service unless the Administrator authorizes the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services rendered by a Non-Network Urgent Care Center will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

Home Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.

- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Inpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.

- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia**.
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

Maternity Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to the Administrator.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copayment.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

  1. the antepartum, intrapartum, and postpartum course of the mother and infant;
  2. the gestational stage, birth weight, and clinical condition of the infant;
  3. the demonstrated ability of the mother to care for the infant after discharge; and
  4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.

- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

  1. parent education;
  2. assistance and training in breast or bottle feeding; and
  3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

  At your discretion, this visit may occur at the Physician's office.

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia.

- Galactosemia.
- Maple Syrup urine disease.
- Homocystinuria.
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
- Physiologic hearing screening examination for the detection of hearing impairments.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by the Administrator, on behalf of the Employer. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

The Administrator, on behalf of the Employer, may establish reasonable quantity limits for certain supplies, equipment or appliance described below. A detailed listing of supplies, equipment or appliances that are not covered by the Plan including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card or visit the Administrator's website at www.anthem.com. This list is subject to change.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that the Administrator approves are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Anthem's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the Anthem Mail Service or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

  1. Allergy serum extracts
  2. Chem strips, Glucometer, Lancets
  3. Clinitest
  4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. The Plan may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.
  5. Needles/syringes
  6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

  Non Covered Services include but are not limited to:

  1. Adhesive tape, band aids, cotton tipped applicators
  2. Arch supports
  3. Doughnut cushions
  4. Hot packs, ice bags
  5. vitamins
  6. medijectors

  If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable Medical Equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

  Covered Services may include, but are not limited to:

  1. Hemodialysis equipment
  2. Crutches and replacement of pads and tips
  3. Pressure machines
  4. Infusion pump for IV fluids and medicine
  5. Glucometer
  6. Tracheotomy tube
  7. Cardiac, neonatal and sleep apnea monitors
  8. Augmentive communication devices are covered when the Administrator approves based on the Member's condition.

  Non Covered items may include but are not limited to:

  1. Air conditioners
  2. Ice bags/coldpack pump
  3. Raised toilet seats
  4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
  5. Translift chairs
  6. Treadmill exerciser
  7. Tub chair used in shower.

  If you have any questions regarding whether specific durable medical equipment is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non Covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.

5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices may include, but are not limited to, the following:

  1. Cervical collars.
  2. Ankle foot orthosis.
  3. Corsets (back and special surgical).
  4. Splints (extremity).
  5. Trusses and supports.
  6. Slings.
  7. Wristlets.
  8. Built-up shoe.
  9. Custom made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non Covered Services include but are not limited to:

  1. Orthopedic shoes (except therapeutic shoes for diabetics).
  2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
  3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
  4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -** Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

    1. determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
    2. not solely for comfort or convenience.

  Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

  Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan. They are also subject to a separate lifetime maximum and do not apply to the Plan Lifetime Maximum.

Outpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by the Administrator, on behalf of the Employer. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Pervasive Developmental Disorder Services

Coverage is provided for the treatment of pervasive developmental disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any Exclusion or limitation in this Benefit Booklet in conflict with the coverage described in this provision will not apply. Coverage for pervasive developmental disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Plan.

Physician Home Visits and Office Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care", and "Home Care Services" for services covered by the Plan. For Emergency Care refer to the "Emergency Care and Urgent Care" section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Preventive Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Preventive Care services include Inpatient services, Outpatient services and Physician Home Visits and Office Services. These services may vary based on the age, sex, and personal history

of the individual, and as determined appropriate by the Administrator's clinical coverage guidelines. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.) Examinations include, but are not limited to:
  1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
  2. Adult routine physical examinations.
  3. Pelvic examinations.
  4. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
  5. Annual dilated eye examination for diabetic retinopathy.

- Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians.

  These include, but are not limited to:

  1. Hepatitis A vaccine.
  2. Hepatitis B vaccine.
  3. Hemophilus influenza b vaccine (Hib).
  4. Influenza virus vaccine.
  5. Rabies vaccine.
  6. Diphtheria, Tetanus, Pertussis vaccine.
  7. Mumps virus vaccine.
  8. Measles virus vaccine.
  9. Rubella virus vaccine.

10. Poliovirus vaccine.

- Screening examinations:

    1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts.
    2. Routine hearing screening.
    3. Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
    4. Routine cytologic and chlamydia screening (including pap test).
    5. Routine bone density testing for women.
    6. Routine prostate specific antigen testing.
    7. Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Diabetes Self Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Medical Nutritional Therapy limited to consultations for the Medically Necessary management and treatment of obesity. Any Prescription Drug or medical supply prescribed as a part of this therapy will not be covered except as otherwise stated under this Benefit Booklet.

Surgical Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;

- Usual and related pre-operative and post-operative care;
- Other procedures as approved by the Administrator, on behalf of the Employer.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Administrator, on behalf of the Employer, for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Surgical Services for Morbid Obesity, described in more detail below, shall be covered the same as any other Medically Necessary Surgical Service subject to any maximums in the Schedule of Benefits.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See “Mastectomy Notice” below for further coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Morbid Obesity Treatment Services

Covered Services include surgical treatment of morbid obesity:

- that has persisted for at least five (5) years; and
- for which nonsurgical treatment supervised by a Physician has been unsuccessful for at least six (6) consecutive months.

The Plan will not cover services for the surgical treatment of morbid obesity for a Member younger than 21 years of age unless two (2) Physicians licensed under Indiana Code 25-22.5 (one who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana) determine that the surgery is necessary to:

- save the life of the Member; or

- restore the Member's ability to maintain a major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency);

and each Physician documents in the Member's medical record the reason for the Physician's determination.

"Morbid obesity" means:

- a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

Surgical Treatment for Morbid Obesity may be limited. See the Schedule of Benefits.

Sterilization

Sterilization is a Covered Service.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Therapy Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, or vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft

tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage the Plan will not require you to receive dialysis treatment at a Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Human Organ and Tissue Transplant Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of the Employer, including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 -50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility or the later of 30 days or date of discharge following a Covered Transplant Procedure at a Non-Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize your benefits, the Administrator strongly encourages you to call its transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. The Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or Exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator.** Even if the Administrator issues a prior approval for the Covered Transplant Procedure, you or your Provider must call the Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation, Meals and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator, on behalf of the Employer, when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility, lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must

submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Prescription Drug Benefits

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pharmacy Benefits Manager

The pharmacy benefits available to you under the Plan are managed by the Administrator's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Administrator contracts to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, a Specialty Pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and operating a Mail Service pharmacy, and a Specialty Drug Pharmacy Network. The PBM, in consultation with the Administrator, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Administrator at the Customer Service telephone number on the back of your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The Administrator, or the PBM, use pre-approved criteria, developed by the Administrator's Pharmacy and Therapeutics Committee which is reviewed and adopted by the Administrator. The Administrator or the PBM may contact your Provider if additional

information is required to determine whether Prior Authorization should be granted. The Administrator communicates the results of the decision to both you and your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Member Grievances section of this Benefit Booklet.

For a list of the current Drugs requiring Prior Authorization, please contact the Administrator at the Customer Service telephone number on the back of your ID card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your Plan. Refer to the Prescription Drug benefit sections in this Benefit Booklet for information on coverage, limitations and Exclusions. Your Provider or Network Pharmacist may check with the Administrator to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

Therapeutic Substitution of Drugs is a program approved by the Administrator and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. The Administrator, or the PBM, may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, contact the Administrator by calling the Customer Service telephone number on the back of your ID card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

Step Therapy

Step therapy protocol means that a Member may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Specialty Pharmacy Network

The Administrator's Specialty Pharmacy Network is available to members who use Specialty Drugs.

"Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Network Specialty Pharmacies may fill both retail and mail service Specialty Drug Prescription Orders, subject to a 30 day supply for Retail and Mail Service, and subject to the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

Network Specialty Pharmacies have dedicated patient care coordinators to help you manage your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists to answer questions regarding your medications.

You may obtain a list of the Network Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your ID card, or review the lists on the Administrator's website at www.anthem.com.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact the Administrator to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Smoking Cessation Prescription Drugs (no over the counter drugs).
- Contraceptive devices, oral immunizations, and biologicals. If such items are cover the counter Drugs, devices or products, they are not Covered Services.
- Treatment of Onchomycosis (toenail fungus).

Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other non Covered Services)

- Over the counter drugs
- Over the counter vitamins
- Prescription vitamins (covered if treating a medical condition)
- Retin-A (covered if treating a medical condition)
- Diet Pills (Anorexiants)
- Fluoride Supplements

- Experimental/ Investigative Drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and Coinsurance/Copayment amount may also apply.

Days Supply

The number of days supply of a Drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days supply allowed for under this Plan, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

Tiers

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by the Plan as a first, or second, or third, or fourth "tier" Drug. The determination of tiers is made by the Administrator, on behalf of the Employer, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 generally includes Generic Prescription Drugs.
- Tier 2 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs.
- Tier 3 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other Drugs in lower tiers.
- Tier 4 generally includes injectable Drugs. The list of Tier 4 Drugs can be found at www.Anthem.com or by calling the number on the back of your Identification Card.

Special Programs

From time to time the Administrator may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic

Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program

The Half-Tablet Program will allow Members to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "½ tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member's decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the Administrator at the number on the back of your Identification Card.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy**,** including a Network Specialty Pharmacy**,** a Non-Network Pharmacy, or the Anthem Mail Service Program. It is also based upon which Tier the Administrator has classified the Prescription Drug or Specialty Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The Administrator, on behalf of the Employer, retains the right at its discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network or Specialty Drug Network Pharmacy or through the Anthem Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to the Administrator with a written request for refund.

Specialty Drugs - You or your Physician can order your Specialty Drugs directly from PrecisionRx Specialty Solutions OR a Specialty Network Pharmacy, simply call 1-800-870-6419. If you or your Physician orders your Specialty Drugs from Precision Rx Specialty Solutions you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate the shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

Non-Network Pharmacy – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to the Plan for reimbursement consideration. These forms are available from the Administrator and/or the Employer. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to the Plan. The itemized receipt must show:

- name and address of the Non-Network Pharmacy;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the Drug;
- cost of the prescription;
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

Anthem Mail Service – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill.

NON COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded and are not considered Covered Services. Unless otherwise stated in this Plan's Benefits' Article, no benefits are provide for care and supplies related to:

- Human organ or tissue transplants other than as specifically stated as covered in the Benefits' Article.
- Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
- Artificial insemination.
- In vitro fertilization.
- Gamete intra fallopian transfer (GIFT).
- Immunizations except as specifically stated.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Reversal of sterilization.
- Services or supplies prescribed, ordered or referred by or received from a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- Hearing aids or examinations for prescribing or fitting them.
- Services, supplies, or charges which the Plan determines are not Medically Necessary or do not meet the Plan's medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional. This includes services at residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Dental treatment, regardless of origin or cause, except as specified elsewhere in this Plan's Benefits' Article. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service as stated in this Plan's Benefits' Article) or gums, including but not limited to: extraction, restoration and replacement of teeth;
  - Medical or surgical treatments of dental conditions; and
  - Services to improve dental clinical outcomes.

- Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Dental implants.
- Dental braces.
- Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
    1. Transplant preparation;
    2. Initiation of immunosuppresives; or
    3. Direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Health Care benefit as specifically stated in this Plan's Benefits' Article.
- Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    1. cleaning and soaking the feet;
    2. applying skin creams in order to maintain skin tone; or
    3. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- Any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- Examinations relating to research screenings.
- Developmental delays except for Pervasive Developmental Disorders (including Asperger's syndrome and autism) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, learning disabilities, hyperkinetic syndromes, or mental retardation (except for Prescription Drugs).
- Illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
- Services and supplies for which you have no legal obligation to pay in the absence of this or like coverage.
- Services and supplies incurred prior to your Effective Date.
- Services and supplies incurred after the termination date of this coverage except as specified elsewhere.
- Services or supplies provided by a sanitarium, or rest cures.

- Services or supplies furnished by any person or institution acting beyond the scope of her/his/its license.
- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
- Services and supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Services and supplies to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Plan or specifically stated as a Covered Service. Services or supplies if the Plan does not state that benefits are provided for them.
- Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Plan.
- Missed or canceled appointments.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Recreation or diversional therapy.
- The cost of materials used in any Occupational Therapy.
- Personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
- Hospitalization for environmental change or Provider charges connected with prescribing an environmental change.
- Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in this Plan's Benefits' Article. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity as required by law are covered. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- The treatment of abuse of nicotine from tobacco or other sources, except for nicotine substitutes, which require a prescription under federal law.
- Stand-by charges of a Physician.
- Sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- Drugs in quantities which exceed the limits established by the Plan.

- The Prescription Drug Copayment/Coinsurance portion of the Pharmacy Benefits Manager.
- Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Diagnostic testing or treatment related to infertility.
- Marital counseling.
- Services and supplies received from an individual or entity that is not a Provider, as defined in this Plan's Benefits' Article, or recognized by the Plan.
- A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Expenses incurred at a health spa or similar facility..
- Self-help training and other forms of non-medical self care, except as otherwise provided herein.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, or for licensing.
- Services and supplies for Skilled Nursing Facilities.
- EXPERIMENTAL/INVESTIGATIVE SERVICES
  Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which The Plan determines to be Experimental/Investigative is not covered under the Plan.

  The Plan will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:
  - cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
  - has been determined by the FDA to be contraindicated for the specific use; or
  - is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
  - is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
  - is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety,

toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Plan. In determining whether a Service is Experimental/Investigative, the Plan will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Plan to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

- Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- Court ordered testing or care unless Medically Necessary.
- Charges in excess of the Maximum Allowable Amount.
- Procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law. Complications directly related to cosmetic services treatment or surgery are not covered.
- Vision orthoptic training.
- Care received in an emergency room which is not Emergency Care, except as specified as covered.
- Chiropractic services rendered in the home as part of Home Care Services.
- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
- Hiring, or the services of, a surrogate mother.
- Surgical treatment of gynecomastia.
- Treatment of hyperhydrosis (excessive sweating).
- Any service for which a Covered Person is responsible under the terms of this Plan to pay a Coinsurance or Deductible, and the Coinsurance or Deductible is waived by a non-Network Provider.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Elective abortions.

ELIGIBILITY AND ENROLLMENT

You have coverage provided under the Plan because of your employment with/membership with/retirement from the Employer. You must satisfy certain requirements to participate in the Employer's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Employer or state and/or federal law and approved by the Administrator, on behalf of the Employer.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

(1) All active full-time (37.5 hours per week) employees and their eligible "dependents".
(2) All appointed or elected officials and their eligible "dependents".
(3) Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.
(4) "Dependent" means:
   a) Spouse of an employee;
   b) Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or Spouse, or children who reside in the employee's home for whom the employee or Spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "Dependent" until marriage or the end of the Calendar Year in which he/she attains age 19/23.
      In the event a child who is a "Dependent" as defined herein, is both:
      1. incapable of self-sustaining employment by reason of mental or physical disability, and
      2. is chiefly dependent upon the employee for support and maintenance;
      prior to age 19, such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The Plan requires annual documentation from a physician after the child's attainment of the limiting age.
(5) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator" who meets the following:
   a) Is no longer a member of the General Assembly;
   b) Who served as a legislator for at least 10 years.
      A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's Spouse covered under the health insurance program. In

addition, the surviving Spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:

1. The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;
2. The surviving Spouse files a written request for insurance coverage with the employer;
3. The surviving Spouse pays an amount equal to the employer's and employee's Premium for the group health coverage for an active employee.

The eligibility of the retired legislator's Spouse, or a surviving Spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The Spouse's eligibility ends on the earliest of the following:

1. When the employer terminates the health coverage program;
2. The date of the Spouse's remarriage;

"Dependent" for a "Retired Legislator" means a person who:

a. Is a dependent child, stepchild, foster child, or adopted child of a former legislator or Spouse of a former legislator or a child who resides in the home of a former legislator or Spouse of a former legislator who has been appointed legal guardian for the child; and
b. Is less than twenty-four (24) years of age; at least twenty- four (24) years of age, incapable of self-sustaining employment by reason of mental or physical disability, and is chiefly dependent on a former legislator or Spouse of a former legislator for support and maintenance; or at least twenty- four (24) years of age.

(6) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

a) Must retire before January 1, 2007
b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
c) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
d) Must have fifteen (15) years of participation in a retirement fund.

(7) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

i. Must retire after December 31, 2006.
ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
iii. Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

(8) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

i. Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

iii. Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

(9) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:
   a) Retirement date is after June 30, 1990;
   b) Will have reached the age of sixty-two (62) on or before retirement date;
   c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
   d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

(10) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:
   a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;
   b) Whose retirement date is after January 1, 1990;
   c) Who is at least sixty-two (62) years of age;
   d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
   e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

(11) Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. The Spouse's subsequent eligibility to continue insurance under the surviving Spouse's eligibility end on the earliest of the following:
   a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;
   b) When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
   c) The end of the month following remarriage; or
   d) As otherwise provided in I.C. 5-10-8-8(g).

(12) Employee on a leave of absence for ninety (90) days or less and out of pay status

(13) An employee on family leave

(14) Retirees eligible under IC 5-10-12.

(15) A former legislator, dependent, or Spouse as defined and pursuant to the conditions set forth in IC 5-10-8-8.2.

(16) All active and retired full-time and part-time employees, elected or appointed officers and officials of a local unit of government that elect to provide health coverage under this plan. A local unit of government is defined as follows:
   a) A city, town, county, township, public library, or school corporation
   b) Any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either the state or a city, town, county, township, public library, or school corporation, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.

(17) As otherwise provided by Act of the Indiana General Assembly.

Effective Date of Your Coverage

"For specific information concerning your Effective Date of coverage under this Plan, you should see your Human Resources or benefits department."

Coverage for a newborn child is effective from the moment of birth. Covered Services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Newborn must be formally added to the Employee's policy through 'family status" change process. See NEWBORN INFANT COVERAGE.

Newborn Infant Coverage

The benefits payable for covered Dependent children shall be paid for a sick or injured newborn infant of a Covered Person for the first 30 days of his or her life. The coverage for newly adopted children will be the same as for other covered Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:

    a) The date of placement for the purpose of adoption; or
    b) The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;

2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or

3. Continues unless required action as described below is not taken.

To be covered beyond the first 30 days, the newborn or newly adopted child must be added to the Covered Person's Plan enrollment within the first 30 days after birth or adoption.

If the Enrolle must change to coverage with a higher fee to add the child, the Enrollee will be liable for the higher fee for the entire period of the child's coverage, including the first 30 days.

Federal Laws Related to Your Coverage

In the past few years, Congress has passed several laws that have affected our group health plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their Dependents who are either age 65 or over, or disabled to elect either:

a) our group health plan, or
b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as you remain covered under our group medical plan.

CHANGES IN COVERAGE: TERMINATION, CONTINUATION & CONVERSION

Termination

Individual Termination

Your coverage will terminate on the earliest of the following dates:

- On the date the group Plan is terminated.
- On the last day of the period for which Premiums have been paid, if the State of Indiana fails to pay the required Premiums for you, except when resulting from clerical mistake or inadvertent error.
- On the last day of the period for which Premiums have been paid in which you leave or are dismissed from employment.
- On the date your Dependent(s) cease(s) to be a covered Dependent.
- Upon the date of your death, coverage for your Dependents shall terminate at the end of the period for which Premiums have been paid.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another group health Plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certifications may be requested within 24 months of losing coverage. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.

Continuation

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Employer which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health plan. It can also become available to other Members of your family, who are covered under the Employer's health plan, when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Employer's health plan, you should contact the Employer.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer's health plan is lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for Fee payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Employer's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Employer's health plan as a "Dependent child."

If Your Employer Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Employer's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also

become qualified beneficiaries if bankruptcy results in the loss of their coverage under Employer's health plan.

When is COBRA Coverage Available

The Employer will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then the Employer will notify the COBRA Administrator (e.g., Human Resources, external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to a total of 18 months. In the case of losses of coverage due to the Subscriber's death, divorce or legal separation, the Subscriber's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Employer's health plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement.

How Can You Extend The Length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

- **Disability**

  An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Employer within 60 days of receipt. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Employer of that fact within 30 days after SSA's determination.

- **Second Qualifying Event**

  An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Subscriber, divorce or separation from the covered Subscriber, the covered Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Employer's health plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Employer within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Trade Act of 1974

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Employer health plan coverage ended.

If you, the Subscriber, qualify for assistance under the Trade Act of 1974, you should contact the Employer for additional information. You must contact the Employer promptly after qualifying for assistance under the Trade Act of 1974 or you will lose these special COBRA rights.

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Employer rate (unless your coverage continues beyond 18 months because of a disability. In that case, Premium in the 19th through 29th months may be 150% of the Employer rate).

Continuation coverage will be terminated before the end of the maximum period if:

- any required Premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another Employer health plan that does not impose any pre-existing condition Exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Employer would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your Employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

1. The 24-month period beginning on the first date of your absence from work; or
2. The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan. No Exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Employer must provide the Administrator with evidence satisfactory to the Employer of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider, or the Administrator to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets the Plan's enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with the Plan.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. The Administrator, on behalf of the Employer, has final authority to determine the Medical Necessity of the service.

The Administrator, on behalf of the Employer, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. Any further changes will be your responsibility. You may appeal this decision. See the **Member Grievances** section of this Benefit Booklet.

- **Network Providers -** include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with the Administrator to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatrician or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physician who provide specialty medical services not normally provided by a PCP.

For services rendered by Network Providers:

1. You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Coinsurance, Copayments and/or Deductibles. You may be billed by your Network Provider(s) for any **non Covered** Services you receive or when you have not acted in accordance with the Plan.

2. Health Care Management is the responsibility of the Network Provider.

If there is no Network Provider who is qualified to perform the treatment you require, contact the Administrator prior to receiving the service or treatment and the Administrator, on behalf of the Employer, may approve a Non-Network Provider for that service as an Authorized Service.

Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider, see your Schedule of Benefits.

For services rendered by a Non-Network Provider, you are responsible for:

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers**,** including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under the Plan has the right to services or benefits under the Plan. If anyone receives services or benefits to which they are not entitled to under the terms of this Benefit Booklet, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

A claim must be filed for you to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

Maximum Allowable Amount

The amount that the Administrator, on behalf of the Employer, or the Administrator's Subcontractor, determines is the maximum payable for Covered Services you receive. To determine the Maximum Allowable Amount for a Covered Service, the Administrator or the Administrator's Subcontractor use, in addition to other information, internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement for this product, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Administrator for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, the Administrator, on behalf of the Employer, shall have discretionary authority to establish as the Administrator deems appropriate, the Maximum Allowable Amount. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount determined by the Administrator, after consideration of any one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that the Administrator may have made, or other factors the Administrator, on behalf of the Employer, deems appropriate.

It is your obligation to pay any Coinsurance, Copayments and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its participation agreement with the Administrator, on behalf of the Employer.

Member Share of Cost

What you pay often depends on the type of service you receive and if you use a Network or Non-Network Provider. Refer to the "Schedule of Benefits" section of this Benefit Booklet to see what amount you are required to pay for each Covered Service.

This Plan shares the cost of your medical expenses with you up to a pre-determined amount, or the Maximum Allowable Amount. The Plan will not pay any portion of any charge that exceeds this amount.

Services may be subject to a Coinsurance, Copayment and/or Deductible, as outlined in the Schedule of Benefits. Deductibles will be based on the Maximum Allowable Amount. Coinsurance and Copayments are your share of the cost for Covered Services, and must be paid at the time you receive the Covered Services. The Plan pays the share of the balance up to the Maximum Allowed Amount.

Network Providers will seek payment from the Plan for Covered Services for the Maximum Allowable Amount, and will accept this amount as full payment.

If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual amount billed and the Maximum Allowable Amount, plus any Deductible, Coinsurance, Copayments and charges for **non Covered** Services.

However, these guidelines change when you receive Covered Services in a Network Provider facility, but from a Non-Network Provider. If you receive Covered Services in a Network Provider facility from a Non Network Provider such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this product. You may be liable for the difference between the billed charge and the Plan’s Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Plan will not pay any portion of any charge that exceeds the Maximum Allowable Amount.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the plan’s Maximum Allowable Amount. **If services are performed by Non Network Providers,** then you are responsible for

any amounts charged in excess of the Plan's Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Administrator for more information.

Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, the Plan will not honor a request to withhold payment of the claims submitted.

Notice of Claim

The Plan is not liable, unless the Administrator receives written notice that Covered Services have been given to you. The notice must be given to the Administrator, on behalf of the Employer, within 90 days of receiving the Covered Services, and must have the data the Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Administrator needs to process the claim, then the necessary data must be submitted to the Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Administrator has not received the information it needs to process a claim, the Administrator will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator, on behalf of the Employer, will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete the Administrator's processing of the claim within 15 days after the Administrator's receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If the Administrator is unable to complete processing of a claim because you or your Provider fail to provide the Administrator with the additional information within 60 days of its request, the claim will be denied and you will be financially responsible for the claim.**

Failure to give the Administrator notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Time Benefits Payable

The Plan will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If the Administrator has not received the information it needs to process a claim, the Administrator will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete the Administrator's processing of the claim within 15 days after the Administrator's receipt of all requested information.

At the Plan's discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, the Plan may reimburse those other parties and be fully discharged from that portion of its liability.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Administrator, or contact Customer Service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the claim forms, written notice of services rendered may be submitted to the Administrator without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits (EOB)

After you receive medical care, you will generally receive an explanation of benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from the Plan to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

BlueCard Program

When you obtain health care services through the BlueCard Program outside the geographic area the Administrator serves, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Administrator, on behalf of the Employer.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Administrator, on behalf of the Employer, would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area the Administrator serves if the Plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area the Administrator serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area the Administrator serves. But in no event will you be

entitled to benefits for health care services, wherever you received them, that are specifically excluded or limited from coverage by the Plan.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your Identification Card or go to www.anthem.com for more information about such arrangements.

HEALTH CARE MANAGEMENT

Health Care Management includes the processes of Precertification, Predetermination and Medical Review. Its purpose is to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources and optimizing the health of the Members. These processes are described in the following section.

If you have any questions regarding the information contained in this section, you may call the Precertification telephone number on the back of your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify the Administrator within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Administrator will review your Benefit Booklet to determine if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Benefit Booklet or is Experimental/Investigative as that term is defined in this Benefit Booklet.

Medical Review – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Administrator has a related clinical coverage guideline and are typically initiated by the Administrator.

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. The ordering Provider, facility or attending Physician will contact the Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services provided by a Network Provider	**Services provided by a BlueCard/Non-Network/Non-Participating Provider**
Provider	• Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are/is not covered under the Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

The Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Benefit Booklet and the Administrative Services Agreement take precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, contact the Precertification telephone number on the back of your Identification Card.

Request Categories:

Urgent – a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.
Prospective – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
Concurrent - a request for Precertification or Predetermination that is conducted during the course of treatment or admission.
Retrospective - a request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, the Administrator will abide by state regulations.

You may call the telephone number on the back of your membership card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	2 business days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request

If additional information is needed to make the Administrator's decision, the Administrator will notify the requesting Provider and send written notification to you or your authorized representative of the specific information necessary to complete the review. If the Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in the Administrator's possession.

The Administrator will provide notification of its decision in accordance with state and federal regulations. Notification may be given by the following methods:

Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the member or authorized member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

1. you must be eligible for benefits;
2. Premiums must be paid for the time period that services are rendered;
3. the service or surgery must be a covered benefit under the Plan;
4. the service cannot be subject to an Exclusion under the plan, including but not limited to a Pre-Existing Condition limitation or Exclusion; and
5. you must not have exceeded any applicable limits under the Plan.

CARE MANAGEMENT

Care Management is a Health Care Management feature designed to help promote the timely coordination of services for Members with health-care related needs due to serious, complex, and/or chronic medical conditions. The Administrator's Care Management programs coordinate health care benefits and available services to help meet health-related needs of Members who are invited and agree to participate in the Care Management Program.

The Administrator's Care Management programs are confidential and voluntary. These programs are provided at no additional cost to You and do not affect Covered Services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Members who meet program requirements/criteria and who agree to participate in a Care Management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Member and/or Member's designated representative, treating Physician(s), and other Providers. The licensed health care professional remains in contact with the Member by telephone on a periodic basis to help accomplish the goals of the plan.

In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Member's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

Value-Added Programs

The Administrator may offer health or fitness related programs to the Plan's Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under the Plan and could be discontinued at any time. The Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact the Plan, either orally or in writing to obtain information on the Plan's Grievance procedures or to file a Grievance with the Plan.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with the Plan on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with the Plan that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, the Administrator must obtain a signed Designation of Representation form from you before the Administrator can deal directly with your representative. The Administrator will forward a Designation of Representation form to you for completion. If the Administrator does not obtain a signed Designation of Representation form, the Administrator will continue to research your Grievance but will respond only to you unless a signed Designation of Representation form is received.

The Administrator will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's appeal.

To obtain information on the Plan's Grievance procedures or to file a Grievance orally with the Plan, please call the toll free Customer Service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about the Plan's Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call the Administrator at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative. The Administrator will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, mail it to: Anthem Appeals, PO Box 33200, Louisville, KY 40232- 3200, ATTN: Appeals Specialist. The Administrator's facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon the Plan's receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from the Administrator), an acknowledgment will be sent to you

within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. The Plan's acknowledgment may be oral for those Grievances the Administrator receives orally. All Grievances will be resolved by the Administrator within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from the Administrator).

If your Grievance cannot be resolved within 20 business days due to the Plan's need for additional information and your Grievance does not relate to an adverse certification decision (i.e., Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from the Plan's original request. In the event of an extension, the Administrator, on behalf of the Employer, will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, the Administrator will make a determination based on the information in the Plan's possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member. Within 5 business days after the Grievance is resolved, the Administrator will send a letter to you notifying you of the decision reached.

Appeals

If the Plan's decision under the Grievance process is satisfactory to you, the matter is concluded. If the Plan's decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of the Plan's receipt of your Appeal request. The Plan's acknowledgment may be oral for those Appeals the Administrator receives orally. The Administrator will set a date and time during normal business hours for the Plan's Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not You choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting, unless your Appeal qualifies for Expedited Review. Appeals concerning adverse certification decisions or the denial of any other prior authorization required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by the Administrator. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by the

Administrator. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by the Administrator of the Plan's decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your Physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

The Administrator will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of the Plan's receipt of sufficient information and will communicate the Plan's decision by telephone to your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering Provider, and the facility rendering the service. The Administrator will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. The Plan's decision will be communicated by telephone to your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Plan's determination to you, your attending Physician or ordering Provider, and to the facility rendering the service.

External Grievance

If the Plan's decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

- Your Appeal is regarding:

1. an adverse determination of appropriateness; or
2. an adverse determination of Medical Necessity; or
3. a determination that a proposed service is Experimental/Investigational made by the Administrator or an agent regarding a service proposed by the treating Physician; and

- You or your representative request the External Grievance in writing within forty-five (45) days after You are notified of the Appeal panel's decision concerning your Appeal; and
- The service is not specifically excluded in this Benefit Booklet.

If an External Grievance is requested, the Administrator will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse the Plan's Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization

will notify you and the Administrator of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse the Plan's Appeals decision, the Administrator will notify you or your Provider in writing of the steps the Administrator will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

The Plan expects that you will use good faith to file a Grievance or an Appeal on a timely basis. However, the Administrator will not review a Grievance if it is received by the Administrator after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. The Administrator will accept Appeals filed within 60 days after you are notified of the Plan's decision concerning your Grievance. The Administrator will accept External Grievance requests filed within 45 days after you are notified of the Plan's Appeal decision.

Grievances and Appeals by Members of ERISA Plans

If you are covered under an Employer plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of your right to file a voluntary Appeal if the Plan's response to your Grievance is adverse. Upon your request, the Administrator will also provide you with detailed information concerning an Appeal, including how panelists are selected.

GENERAL PROVISIONS

Entire Contract

This Benefit Booklet , the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Employer and any and all statements made to the Employer by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of the Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can only be made through an endorsement authorized and signed by a person authorized to sign on behalf of the Employer.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that they, in consultation with their Providers, are responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. In this event, the Provider shall have no further responsibility to provide care to you, and the Plan shall have no obligation to have Network Providers available who will render the care.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under the Plan are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by the Plan as far as is practical under the circumstances, and according to their best judgment. However, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Plan.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As an Administrator of your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the customer service number on the back of your Identification Card.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet , Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or

Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an

Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

6. The amount that is subject to the Primary high-deductible health plan’s deductible, if the Administrator has been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

7. Any amounts incurred or claims made under the Prescription Drug program of this Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes

coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;

   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or

   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

     - The Plan covering the Custodial parent;

     - The Plan covering the spouse of the Custodial parent;

     - The Plan covering the non-custodial parent; and then

     - The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THIS PLAN'S BENEFITS

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The Administrator, on behalf of the Employer, may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The Administrator needs not tell, or get the consent of, any person to do this. Each person claiming benefits under the Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than should have paid under this COB provision, the Administrator, on behalf of the Employer, may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan has paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Administrator will calculate benefits as if they had enrolled.

Physical Examination

When a claim is pending, the Plan reserves the right to request a Member to be examined by an applicable Provider. This will be requested as often as reasonably required.

Worker's Compensation

The benefits under the Plan are not designed to duplicate benefits that Members are eligible for under the Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under the Plan does not replace or affect any Worker's Compensation coverage requirements.

Other Government Programs

The benefits under the Plan shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Plan has the first priority for the full amount of benefits it has paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice them.
- The Plan has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses or costs without the Plan's prior written consent. The Plan further agrees that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse the Plan to the extent of benefits the Plan paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
    2. you fail to cooperate.

- In the event that you fail to disclose to the Plan the amount of your settlement, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights.
- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such recovery activity.

The Administrator, on behalf of the Employer, has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Administrator, on behalf of the Employer, may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Administrator, on behalf of the Employer, has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Administrator, on behalf of the Employer, will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Administrator, on behalf of the Employer, may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member Plan)

Neither the Employer nor any Member is the agent or representative of the Plan.

The Employer is responsible for passing information to the Member. For example, if the Plan gives notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to the Plan in a timely manner. If the Employer does not provide the Plan with timely enrollment and termination information, the Plan is not responsible for the payment of Covered Services for Members.

Anthem Blue Cross and Blue Shield Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Booklet constitutes a contract solely between the Employer and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington,

D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Conformity with Law

Any provision of this Plan which is in conflict with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Clerical Error

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or the Plan.

Policies and Procedures

The Employer is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

Under the terms of the Administrative Services Agreement, the Administrator has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Benefit Booklet. The Administrator reserves the right to discontinue a pilot or test program at any time. The Administrator will provide advance written notice to the Employer of the introduction or termination of any such program.

Waiver

No agent or other person, except an authorized officer of the Employer, has able to disregard any conditions or restrictions contained in this Benefit Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Administrator, determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

Anthem shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Grievances and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or Exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. Anthem's determination shall be final and conclusive and may include, without limitation, determination of Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowable Amount. A Member may utilize all applicable Member Grievance procedures.

DEFINITIONS

If a word or phrase in this Benefit Booklet has special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card or submit your question online at www.anthem.com.

Actively At Work – An employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

Administrative Services Agreement - The agreement between the Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's group health plan.

Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Anthem Insurance Companies, Inc. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Administrator, on behalf of the Employer, to be paid at the Network level.

Behavioral Health Conditions –

- **Mental Health Condition** – A display of mental or nervous symptoms that are not a result of any physical or biological cause(s) or disorder(s).
- **Substance Abuse** – A condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to loose control of their actions.

Behavioral Health Services Subcontractor - An organization or entity that the Plan has a contract with to provide administrative and claims payment services and/or Covered Services regarding Behavioral Health services under the Plan. These administrative services may also be provided directly by the Administrator.

Benefit Booklet- This summary of the terms of your health benefits.

Benefit Period – The length of time that the Plan will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.

Benefit Period Maximum – The maximum that the Plan will pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

Covered Services - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under the Plan.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by the Administrator, on behalf of the Employer, if such Prior Authorization is required in this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any Diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before the Plan will pay for those Covered Services in each Benefit Period.

Dependent – A Member of the Subscriber's family who is covered under the Plan, as described in the "Eligibility and Enrollment" Section.

Diagnostic (Service/Testing) – A test or procedure performed on a Member, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a

Member who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services in the Covered Services section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date that a Subscriber's coverage begins under the Plan. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date.

Eligible Person – A person who meets the Employer's requirements and is entitled to apply to be a Subscriber.

Emergency – An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Employer- The legal entity contracting with the Administrator for administration of group health care benefits.

Enrollment Date – The day the Employer or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

Expedited Review – The expedited handling of a Grievance or Appeal concerning the Plan's denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Administrator, on

behalf of the Employer, determines to be unproven. For how this is determined, see the "Non Covered Services/Exclusions" section.

External Grievance- - Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Benefit Booklet.

Family Coverage – Coverage for the Subscriber and all eligible Dependents.

Fee(s)- The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

Formulary - The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Grievance - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or Medically Necessary;
- a determination that a proposed service is Experimental/Investigative;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan or the Employer and the Plan.

Identification Card / ID Card – A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

Late Enrollee – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under the Plan, and who did not qualify for Special Enrollment.

Lifetime Maximum – The maximum dollar amount the Plan will pay for Covered Services during your lifetime. While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

Mail Service – The Anthem Prescription Management program which offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Administrator, and sent directly to your home.

Maximum Allowable Amount -- The maximum amount that the Plan will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary/ Medical Necessity - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an Exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Fee payment; Members are sometimes called "you" or "your" in this Benefit Booklet.

Network Provider – A Provider who has entered into a contractual agreement or is being used by the Administrator, or another organization, which has an agreement with the Administrator, to provide Covered Services and certain administration functions for the Network associated with the Plan.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Provider - A Provider that has been designated as a "center of excellence" by the Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed Drug product but new manufacturer: a product that duplicates another firm's already marketed Drug product (same active ingredient, formulation, or combination);
- Already marketed Drug product, but new use: a new use for a Drug product already marketed by the same or a different firm; or
- Newly introduced generic medication: generic medications contain the same active ingredient as their counterpart brand-named medications.

Non-Network Provider - A Provider who has not entered into a contractual agreement with the Administrator for the Network associated with the Plan. Providers who have not contracted or affiliated with the Plan's designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement nor is otherwise engaged by to render Specialty Drug Services, or with another organization which has an agreement with the Administrator, to provide Specialty Drug services to you for the Specialty Pharmacy Network.

Non-Network Transplant Provider - Any Provider that has **NOT** been designated as a "center of excellence" by the Administrator or has not been selected to participate as a Network Transplant Provider by a designee.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; See Eligibility and Enrollment section for more information.

Out of Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Benefit Booklet and/or the Schedule of Benefits.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Pharmacy and Therapeutics (P&T) Committee – A committee consisting of health care professionals, including Nurses, Pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

Plan – The group health benefit plan provided by the Employer and explained in this Benefit Booklet.

Prescription Order – A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug – A medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under the Plan.

Primary Care Physician ("PCP") – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- **Alcoholism Treatment Facility -** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility –** A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:

  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
  2. Surgery
  3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility -** A facility, with an organized staff of Physicians, that:

  1. Is licensed as such, where required;
  2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. Does not provide Inpatient accommodations; and
  5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Certified Advance Registered Nurse Practitioner**

- **Certified Nurse Midwife**

- **Certified Registered Nurse Anesthetist**

- **Certified Surgical Assistant**

- **Day Hospital -** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Drug Abuse Treatment Facility -** A facility which provides detoxification and/or rehabilitation treatment for drug abuse.

- **Home Health Care Agency -** A facility, licensed in the state in which it is located, which:

  – Provides skilled nursing and other services on a visiting basis in the Member's home; and
  – Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Facility -** A facility which provides a combination of:

  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances

  in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. Provides room and board and nursing care for its patients;
  2. Has a staff with one or more Physicians available at all times;
  3. Provides 24 hour nursing service;
  4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. Nursing care
  2. Rest care
  3. Convalescent care
  4. Care of the aged
  5. Custodial Care

6. Educational care
7. Treatment of alcohol abuse
8. Treatment of drug abuse

- **Laboratory (Clinical)**

- **Licensed Practical Nurse**

- **Licensed Professional Counselors**

- **Occupational Therapist**

- **Outpatient Psychiatric Facility -** A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.

- **Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist**

- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).

- **Psychiatric Hospital -** A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Psychologist -** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse First Assistant**

- **Registered Nurse**

- **Registered Nurse Practitioner**

- **Regulated Physician's Assistant**

- **Rehabilitation Hospital -** A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the

combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified)**

- **Retail Health Clinic** - A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;
  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
  5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

- **Speech Therapist**

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center -** A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Service Area – The geographical area where Our Covered Services are available, as approved by state regulatory agencies.

Single Coverage – Coverage that is limited to the Subscriber only.

Special Enrollment – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

Specialty Care Physician (SCP) - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Stabilize - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and Behavioral Health services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber - An employee or Member of the Employer who is eligible to receive benefits under the Plan.

Therapy Services – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENTS, OR BILLINGS

CUSTOMER SERVICE NUMBER

Business Hours are 8:00 A.M. to 6:00 P.M.

Medical Questions –1-877-814-9709

PRECERTIFICATION

1-877-814-4803

MENTAL HEALTH OR SUBSTANCE ABUSE PROGRAM

1-800-223-7723

EMPLOYEE ASSISTANCE PROGRAM

1-800-223-7723

PHARMACY NETWORK

1-800-662-0210

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL

ADVANTAGE HEALTH SOLUTIONS, INC.

CERTIFICATE OF COVERAGE

***Group*:**			
Policy #:		***Group Contract* Eff:**	**01/01/2009**
***Member* ID #: As Shown on ID Card**			
***Policy maximum*:**	**Unlimited** **See definition**		

***Deductible*:**

Except where indicated, benefits are subject to a $250 *deductible* per member, per calendar year.

Covered services for outpatient prescription drugs are subject to a: $100 *deductible per single and $200 deductible per family* on all Brand Name Drugs per member per calendar year this excludes Diabetic Supplies.

All *Covered Service* are subject to the *Policy maximum* applicable to each *member*.

New Hire Eligibility:

New hires shall become effective on the first (1st) of the month following 45 days of employment.

Dependent Age Limit:

Unmarried children are eligible to the last day of the year in which the child reaches age 24. Any Young Adult child age 19 up to the day of the 24th birthday., regardless of marital status, is eligible for coverage under the Young Adult Rider if the Young Adult is: (1) the natural or adopted children of the subscriber; or (2) the stepchild, grandchild, or other blood relative of the subscriber and the subscriber pays more than 50% of the Young Adult's total support; or (3) the subscriber is the Young Adult's legal guardian and the subscriber pays more than 50% of the Young Adult's total support.

IMPORTANT CONTACTS

(*You* write the name, address and phone number of *your Primary care physician (PCP*) in the spaces provided below)

Your PCP: _____
Address: _____
Telephone: _____

Spouse's *PCP*: _____
Address: _____
Telephone: _____

Dependent's *PCP*: _____
Address: _____
Telephone: _____

Dependent's *PCP* _____
Address: _____
Telephone: _____

ADVANTAGE Health Solutions, Inc. SM **(*ADVANTAGE*)** :

Member Services or Eligibility Department
P.O. Box 80069
Indianapolis, IN 46209
(317) 573-6228 or 1-800-553-8933
TDD: 1- 800 743-3333 (hearing impaired)
Monday-Friday, 7:30 am to 5:30 pm
FAX: (317) 573-2839
NOTE: To ensure quality service, *your* call may be monitored.

TDD (for hearing impaired)
1-800-743-3333

If *you* have limited use and/or understanding of English, *ADVANTAGE* will provide interpreter services to *you* or *your* representative through the AT&T Language Line Services. This service provides immediate access to interpreter services in 150 languages. If *you* are hearing impaired, *ADVANTAGE* will provide interpreter services through the Telecommunications Relay System. Interpreter services are available at no charge to *you*.

Appeals Specialist
9045 River Road, Ste 200
Indianapolis, IN 46240
(317) 573-6689 or 1-888-806-1029
TDD: (800) 743-3333 (hearing impaired)
Monday-Friday, 8:00 am to 5:00 pm
FAX: (317) 573-7403 or 1-866-510-7765

Anti-Fraud Help Line:
1-888-333-9576

Web site
www.*advantage*plan.com

Health Promotion Coordinator
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SECTION 1: WELCOME TO *ADVANTAGE*

This *Certificate of Coverage* and *Member Handbook* (*Certificate*) explains *your* health care benefits under *ADVANTAGE* Health Solutions, Inc.SM (*ADVANTAGE*). It describes the rules of *ADVANTAGE*, how to access medical care, what health care services are covered under *ADVANTAGE*, and what portion of the health care costs *you* will be required to pay.

This *Certificate* is part of the *Group Services Agreement* (*Agreement*) between *ADVANTAGE* and *your* employer *group* (*Group*). The *Agreement* sets the terms and conditions of *coverage*. This *Certificate* describes the health care *covered services* for *you* and *your eligible dependents*. The *coverage* described in this *Certificate* is subject in every respect to the provisions of the *Agreement* issued to *your Group*. If there is any conflict between the *Agreement* and this *Certificate*, the *Agreement* shall prevail.

Please read this *Certificate* in its entirety so that *you* will know how to get the most out of *your* health care benefits and understand *your* responsibilities. In order to provide *you* with clear information, many words in this *Certificate* have special meanings. These words appear in *italics* type and have been defined for *you* within the body of this *Certificate* or in the Glossary of Terms section at the end of this *Certificate*. The terms *"you," "your"* and *"yourself"* refer to the *member*, whether enrolled with *ADVANTAGE* as a *subscriber* or *eligible dependent*.

Our Company

ADVANTAGE is a health maintenance organization organized and licensed in the State of Indiana. *ADVANTAGE*'s strategy is to serve the growing number of *Group*s and the public sector in Indiana that seek to control health care costs and manage employee health benefit plans through the offering of quality managed care products.

ADVANTAGE is an institution operated in accordance with the *Ethical and Religious Directives* for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. *ADVANTAGE* is not required to provide services that are inconsistent with the medical ethics or precepts of the Catholic Church.

Our Mission

ADVANTAGE will be a statewide leader in managed care, offering access to a broad community-based and high-quality delivery system of *providers*; affordable and comprehensive benefit plans; high quality service to our customers; and a corporate environment that fosters physical, mental and spiritual health for our employees.

Based on the core values of fidelity, excellence and quality, dignity of persons, and stewardship, *ADVANTAGE* will continuously strive to enhance the health of our communities through public-private partnership initiatives, a firm company commitment to volunteerism and the belief that…

- Life is enriched through the delivery of compassionate care
- Each person is respected as having intrinsic worth
- In all matters, honesty and integrity, and
- Common beliefs, mission and values that are supported by our Catholic owners' best serve *ADVANTAGE*.

Should *you* have any questions, please call Member Services toll-free at 1-800-553-8933 or (317) 573-6228. We are pleased that *you* have chosen *ADVANTAGE* and look forward to serving *you*.

ALWAYS REMEMBER. . .

- To show *your ADVANTAGE member* ID card every time *you* check in at an appointment.
- Tell *your Group* within 31 days when *you* have a newborn or adopted child.
- Everyone in *your* family should choose a doctor. This doctor will be *your primary care physician* (*PCP*). Each family member may choose a different *PCP*.
- If *you* do not choose a *PCP*, *ADVANTAGE* will choose one for *you*.
- *Your PCP* belongs to a *provider network*. *You* must receive all non-emergency care through *your PCP*'s *provider network*.
- Once *you* choose a *PCP*, *you* should make an appointment to get to know him.
- If *you* miss a scheduled appointment without canceling ahead of time, the doctor may charge *you* for the missed appointment.
- If *you* change to a different *PCP*, it is important to ask the new doctor which *hospital*s and specialists *you* should use.
- If *you* feel *you* have a medical emergency, and if there is time, *you* should call *your PCP* for advice and instructions. If *you* feel that the emergency puts *your* life in danger or could cause a serious disability or is a major threat to *you* or one of *your* family members, *you* should go to the nearest emergency room or call 911.
- If *you* use the emergency room for non-emergency care that is not approved, *you* will be responsible for the bill.
- If *you* have a student dependent, all non-emergency care must be authorized by the student's *PCP*.
- To keep *your PCP* informed of medications prescribed by specialty care *provider*s or behavioral health *provider*s to prevent adverse drug reactions.

YOUR RIGHTS AND RESPONSIBILITIES

You, *your physician* and other health care *providers* are partners in *your* health care. There are certain rights and responsibilities that are critical to this partnership. The manner in which *you* exercise these rights and responsibilities affects our ability to make appropriate medical care available to all our *members*. *You* are entitled to these rights without regard to sex, race, culture, and economic, educational or religious background.

***You* Have the Right…**

- To select a *Primary care physician* (*PCP*) and to change *your Primary care physician* one time a year by contacting Member Services
- To have twenty-four (24) hour access to *your PCP* and if out of town, receive emergency care if necessary
- To receive prompt and appropriate treatment for physical and emotional disorders and disabilities in the least restrictive environment necessary for that treatment, and remain free from unnecessary or excessive medication
- To be informed by *your* health care *provider* of information about *your* diagnosis, treatment and prognosis in a manner that *you* can understand.
- To participate in decisions involving *your* medical care, *you* should receive enough information to enable *you* to make an informed decision before *you* receive any recommended treatment. The information should include a candid discussion of appropriate or *medically necessary* treatment options for conditions, regardless of cost or benefit *coverage*
- To receive information on early *hospital* discharge and follow-up care, rehabilitation and living arrangements that are available once *you* are released from the *hospital*
- To receive appropriate information so *you* may give an informed, voluntary consent to participate in any *experimental* research. (*Experimental* and *investigational* procedures are not covered under *your* Plan.)
- To refuse treatment and to be informed of the probable consequences of *your* action
- To have *your* guardian, next of kin or legally authorized person exercise *your* rights on *your* behalf if *your* medical condition causes *you* to be incapable of understanding or exercising *your* rights
- To know the cost of *your* care and treatment and to receive an explanation of *your* financial responsibility upon request
- To have *your* health records kept confidential except when disclosure is required by law or permitted by *you* in writing. *You* have the right to review *your* medical records with *your Primary care physician* after adequate notice has been given
- To receive guidance and recommendations for additional medical care when *coverage* ends
- To be provided with information about *your* Plan, its *provider*s and *your* rights and responsibilities
- To provide opinions about ADVANTAGE or the care provided by *your* health care *provider* and to recommend changes in policies and services by contacting Member Services
- To be informed about the *grievance* procedures
- To voice complaints or appeals about ADVANTAGE or the care *you* have received and to receive a response to complaints or appeals within a reasonable amount of time
- To be treated with respect and recognition of *your* dignity and right to personal privacy
- To receive advice or assistance in a prompt, courteous and responsible manner
- To review the criteria utilized to make an adverse decision regarding any services requested but denied by our medical management department
- To continue receiving active treatment from *your provider* even if the *provider*'s network status changes (i.e. terminates from the network) until the current treatment period ends or up to 90 days, whichever is shorter
- To make recommendations regarding ADVANTAGE's *member* rights and responsibilities policies

***You* Have the Responsibility . . .**

- To keep scheduled appointments and give adequate notice of appointment delay or cancellation
- To be considerate of other patients and to be understanding and tolerant if any delays should occur
- To provide, to the extent possible, information that ADVANTAGE and its *provider*s need in order to care for *you*
- To communicate openly with the *provider* and medical staff. If *you* have questions or disagree with the treatment plan, *you* have the responsibility to discuss *your* concerns with the medical staff and make certain *you* understand the explanations and instructions
- To be honest, complete and accurate when providing information to the medical staff
- To follow the instructions and guidelines given to *you* by the medical staff and to consider the potential consequences if *you* do not comply
- To follow the plans and instructions for care that *you* have agreed upon with *your provider*s
- To understand *your* health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To understand what medications *you* are taking and whether follow-up care is needed
- To know how to access care in emergency, urgent and routine situations
- To express *your* opinions, concerns, or complaints in a constructive manner to the appropriate personnel with ADVANTAGE or *your* network *provider*
- To know the benefits and *non-covered services* of *your coverage*
- To contact Member Services for all questions and assistance
- To treat all ADVANTAGE and *provider* personnel in a courteous and respectful manner

SECTION 2 – SELECTING A *PRIMARY CARE PHYSICIAN* (*PCP*):

You must select a *PCP* for *you* and each *eligible dependent*. *You* must live or work within thirty (30) air miles of the *PCP you* select. Each *eligible dependent* of *your* family may select a different *PCP*. When selecting a *PCP*, keep in mind *you* may want to select a *physician* that best meets *your* health care and cultural needs. Each *PCP* belongs to a *provider network* that includes *hospitals, specialists (SCPs)* and other health care *provider*s. When *you* choose a *PCP*, *you* also choose the *provider network*.

You can find a list of *hospitals* and *SCPs* included in *your PCP's network* in the *Provider Directory*, or visit *ADVANTAGE*'s web site at www.advantageplan.com.

What is the role of a *PCP*?
Your PCP is *your* primary health care *provider* responsible for coordinating all of *your* health care needs. It is very important that *you* establish a relationship with *your PCP* as soon as possible. *Your PCP* needs to be familiar with *your* heath care needs in order to properly manage *your* care. For *your* safety and well-being, *you* are encouraged to discuss all of *your* health care services with *your PCP*, including specialty care, prescriptions, medical history, etc. If *you* have selected a *PCP* who has not been providing care for *you*, we encourage *you* to contact him/her as soon as possible.

How do I schedule an appointment with my *PCP*?
Call the *PCP*'s office to schedule an appointment. Always identify *your*self as an *ADVANTAGE member*.

Please follow these scheduling tips:
- Always schedule routine visits in advance
- Always have *your member ID card* available.
- If a copayment or coinsurance is required, *you* will be asked to make that payment at the time of *your* visit. The *copayment* or c*oinsurance* amount is shown on *your member ID card*.
- If *you* are unable to keep an appointment with *your physician*, please call *your physician's* office at least twenty-four (24) hours in advance of *your* appointment time to cancel.

ADVANTAGE ensures *you* can obtain health care services in a timely manner for preventive, routine and urgently needed services. The *ADVANTAGE* appointment standards for primary care are:

• Routine preventive care appointments	30 business days
• Routine primary care appointments	10 business days
• *Urgent care* appointments	48 hours
• *Emergency* care appointments	Immediate
• After-hours access	7 days/week; 24 hours/day
• Wait time in *physician* office	Not to exceed 30 minutes

If *your PCP* is not available for *your* appointment and *you* are seen by a partner or on-call *physician*, *you* will only be responsible for the *physician* office visit *copayment* or *coinsurance* shown on *your ID card*.

NOTE: *Members*, who miss scheduled appointments, without canceling with reasonable notice, may be charged by the *provider* for missed appointments.

What do I do if I need medical services after my *PCP*'s normal office hours?
If *you* must reach *your PCP* after normal office hours, *you* may do so by calling the *PCP*'s telephone number listed on *your ID card*. *You* may be uncertain if *you* should call the *PCP* immediately or wait until normal office hours. Remember, routine questions and problems should be handled during normal business hours. Examples of routine questions or problems may include:
- Scheduling appointment for physical exam
- Requesting information regarding *your* child's vaccinations
- Non-*emergency* conditions, such as:
  - Cold or flu symptoms
  - Muscle sprain
  - Skin rash
  - Earache
  - Other symptoms or conditions that do not require immediate medical treatment

If *you* feel *you* should speak with the *physician* immediately, call the *PCP*'s telephone number and follow the instructions provided to *you* by the after-hours answering service.

What if I want to change my *PCP*?
You and *your eligible dependents* may change to a different *PCP* anytime, unless you are under acute treatment and care, or you can change to a different PCP during *your open enrollment period***.** To change to a different *PCP*, please refer to the *Provider Directory* to be sure that the *PCP you* select is accepting new patients. To change to a different *PCP*, *you* may contact the *ADVANTAGE* Member Services Department by phone or visit our website at www.advantageplan.com. See Important Contacts located at the front of this *Certificate*. *Your* new *PCP* selection will become effective the first of the following month after we receive *your* request for change.

A new *ID card* will be mailed to *you* and any of *your eligible dependents* that have changed *PCPs*. It is important to review the *PCP* information on *your ID card* to verify that the *PCP* listed on the card is the *PCP you* selected.

When *you* select a new *PCP* from a different *provider network*, it is important that *you* understand that the *hospital*, *SCPs*, ancillary services, and *behavioral health providers* associated with that *provider network* may be different.

SECTION 2A – SPECIALTY CARE SERVICES:

What are the *covered services*?
Except for services and items listed as *non-covered services* in this *Certificate*, *covered services* include those services for consultation or treatment by a *SCP*, which are *medically necessary*.

What is a *specialty care physician* (*SCP*)?
A *physician* whose training has been concentrated in a specialized field is considered a *SCP*. Examples of *SCPs* would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc. For mental health and substance abuse services, please read the information in the Behavioral Health section of this *Certificate.*

What do I do when I need to see a *SCP*?
You can self-refer to the appropriate *SCP* in *your PCP's provider network* for office visits and consultations. If the *SCP* schedules you for any procedures or special treatment, the services may require *prior authorization*. Please ask the *SCP* to contact *ADVANTAGE*.

ADVANTAGE ensures *you* can obtain health care services in a timely manner for specialty services. The *ADVANTAGE* appointment standards for specialty care are:

- Non-Urgent — Within 20 business days
- Urgent *complaint*s — Within 48 business hours
- *Emergency* Care — Immediate
- After-hours access — 7 days/week; 24 hours/day
- Wait time in *physician* office — Not to exceed 30 minutes

What if my *physician* wants to refer me to a *SCP* outside the *provider network*?
Your physician may determine *you* require treatment by a type of *SCP* that is not available in *your provider network*. When *your physician* refers you to a provider outside of the *provider network*, be sure you or your physician contacts ADVANTAGE prior to your appointment to ensure your benefits are paid correctly.

IDENTIFICATION CARD

Your actual *ID card*(s) will be mailed to *you* in a separate envelope. Each *eligible dependent* is provided with a separate *ID card*. If *you* need replacement *ID cards*, call Member Services at 1-800-553-8933 or (317) 573-6228. Also, you can request a replacement card or print a temporary ID card by visiting our website at www.advantageplan.com.

Your ID card provides important information regarding *your copayments* and *coinsurance* (if any) for *physician* office visits, *emergency* and *urgent care* visits, and *hospital coverage*. *Your PCP* name and office telephone numbers are provided on the card. *You* should always carry *your ADVANTAGE* ID card with *you*. The card also has other very important information that *you* and *your physician* will need.

Please note that any claims *you* may receive should be directed to the "Claims Address" shown on the card.

COVERAGE INFORMATION

You must enroll *yourself* and members of *your* family who are *eligible dependents* during *your Group's open enrollment period*. The initial *open enrollment period* will be held for a period no longer than 31 days and will be closed prior to the *effective date* of the *Agreement* with *your Group*. Subsequent *open enrollment period*s will be held at least annually for a period of not more than 31 days, beginning on a date agreed to by the *Group* and *ADVANTAGE* and closing prior to the *renewal date*. During an *open enrollment period*, any *eligible person* and/or *eligible dependent* may join *ADVANTAGE*.

By enrolling in this Plan, *you* understand that *ADVANTAGE* has the right to utilize *your* personal medical information for future, known or routine needs for the purposes of treatment, payment, and health care operations. This may include: coordination of care; case management; disease management; quality assessment and measurement; accreditation; decisions about the payment of services; and other normal business operations related to administering the health plan. Information may be transmitted to or from ADVANTAGE for the purpose of arranging for *your* health care and benefits. ***You* understand this consent is a condition of *your* enrollment in *ADVANTAGE* and *you* have the right to revoke this consent in writing at any time.** *You* also understand you have the right to file a grievance if *you* feel there is a violation regarding use or disclosure of *your* personal health information.

A person who previously had *coverage* voided under *ADVANTAGE* because of: fraud; misrepresentation; misusing an ID card; or failure to make payment, unless payment has since been made in full; may not enroll in *ADVANTAGE*.

Who can be covered under dependent *coverage*?

- *Your* legal *spouse*
- Any unmarried children dependent upon *you* for support through the age specified on the cover page to this *Certificate*.
- Disabled *eligible dependents* already enrolled and are incapable of self-supporting due to mental retardation or physical handicap and are chiefly *dependent* upon the *subscriber* or *subscriber's spouse* for support and maintenance at the time he or she reaches the limiting age may remain a covered *eligible dependent for the duration of the disability and dependency*. *ADVANTAGE* must certify the *dependent's* eligibility under a disability status. *ADVANTAGE* must be informed of the *dependent's* eligibility for continuation of *coverage* within 120 days after the *dependent* reaches the limiting age and subsequently, at reasonable intervals during the two years following the *dependent's* attainment of the limiting age. *ADVANTAGE* may require proof once per year in the time following the two year period after the *dependent's* attainment of the limiting age. The proof must include a statement by a licensed psychologist, psychiatrist, or other *physician* and proof of continued dependency. *ADVANTAGE* requires such proof of the person's disability/dependency within 30 days of the request.

  If a *dependent* of the *subscriber* or *spouse* who attained the limiting age while covered under another health care policy meets the criteria specified above, the *dependent* is an *eligible dependent* for enrollment so long as no break in *coverage* longer than 63 days has occurred immediately prior to enrollment. *ADVANTAGE* will require proof of disability as described above.
- Court-Ordered *Coverage*: A court or administrative agency of competent jurisdiction orders *you* or *your* family members to provide health *coverage* for a child under age 18. The child may be enrolled by his custodial parent; his non-custodial parent; the office of Medicaid Policy and Planning; or a Title IV-D agency. The date of status change is the date the order is issued.

  If *you* are required by a Qualified Medical Child Support Order or court order, as defined by the Employee Retirement Income Security Act or applicable state law, *you* may enroll *your* child in *ADVANTAGE* without regard to any enrollment limits. *Your* child will be eligible to receive the *covered services* described in this *Certificate* in accordance with the requirements of such order. A child's *coverage* under this provision will not extend beyond the age limits described on the cover page of this *Certificate*. Any claims payable under this *Certificate* will be paid at *our* discretion to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. *ADVANTAGE* will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to *us* directly.

NOTE: Enrollment is allowed any time after the order is issued. The amount *you* must contribute toward the *premium* fee may increase when *your* newly *eligible dependent* is added.

- Who is eligible for coverage under the Young Adult Coverage Rider?
  - A *Young Adult,* regardless of marital status, between the ages of 19 and 24 can be covered on the *Young Adult* Coverage Rider if the *Young Adult* meets any of the following criteria:
    (1) the natural or adopted child of the subscriber;
    (2) the step-child, grandchild, or other blood relative of the subscriber and the subscriber pays more than fifty percent (50%) of the *Young Adult's* total support; or
    (3) The subscriber is the *Young Adult's* legal guardian and the subscriber pays more than fifty percent (50%) of the *Young Adult's* total support.
  - The *Young Adult's* coverage is a Rider to the subscriber coverage with ADVANTAGE, it is not individual coverage. If the subscriber's coverage terminates for any reason, coverage under the *Young Adult* Rider terminates.
  - A *Young Adult* may elect coverage at open enrollment. If a group does not have an annual open enrollment the Young Adult may elect coverage upon renewal of the group contract.
  - For a *Young Adult* that is entitled to a *Special Enrollment Period*, the provisions for all *Special Enrollment Periods* apply.
  - Medical care for a *pre-existing condition* of a *Young Adult* may be subject to a six (6) month limitation of benefits as provided in Section 5 of this *Certificate.*
  - A *Young Adult* may not enroll his/her spouse or children.

What do I do when there is a change in my family status?
In order to avoid problems for proper claims payments, it is very important that *you* let *your Group* know of any and all changes in *your* family status. Examples of family status changes include:

- Marriage – *you* must notify your employer within 31 days from the date in which you married that you wish to enroll your spouse in ADVANTAGE for coverage.
- Newly Adopted Child **-** Adopted children are eligible for *coverage* as of the earlier date of placement with *you* and/or *your spouse*, or the date of the entry of the order granting the adopting parent custody of the child for purposes of adoption. The adopted child is automatically entitled to receive *covered services* for the first 31 days as of earlier date of placement with *you* and/or *your spouse*, or the date of entry of the order granting the adopting parent custody of the child for purposes of adoption. In order for *coverage* to continue beyond the first 31 days, *you* must notify *your* employer that *you* wish to enroll the child in *ADVANTAGE* for *coverage* to continue beyond the first 31 days. If *you* do not notify *your Group* within 31 days, then the rules applicable to *late enrollees* apply, as discussed later in this *Certificate*. In that case, *you*, not *ADVANTAGE*, will be responsible for payment of services, which were provided to the child after the 31st day.
- Birth of a child - A child newly born to *you* or to *your* enrolled *eligible dependent*, or adopted by *you* within 31 days of birth, is automatically entitled to receive *covered services* for the first 31 days from date of birth. **Within 31 days of birth, *you* must notify *your* employer that *you* wish to enroll *your* newborn in *ADVANTAGE* for *coverage* to continue beyond the first 31 days.** If *you* do not notify *your Group* within 31 days, the child will be declared ineligible for *covered services* after 31 days from date of birth. In that case, *you*, not *ADVANTAGE*, will be responsible for payment of services, which were provided to the child after the 31st day. Nor will *ADVANTAGE* arrange or provide for the child's care after the 31st day in that case. If newborn is not a child born to *you* or *your spouse*, or is not covered as an adopted child or guardian situation, then newborn shall not be eligible for *coverage* beyond the 31st day. If *you* do not notify *your Group* within 31 days, then the rules applicable to *late enrollees* apply, as discussed later in this *Certificate*.
- Guardianship – Children under the guardianship of *you* or *your spouse* are eligible for *coverage* as of the earlier of:
  - the date of placement with *you* or *your spouse*, or
  - The *effective date* of guardianship under *you* or *your spouse*.
  - The enrollment process and applicable *premium* payment must occur within 31 days of either the placement or date of the legal guardianship for *coverage* to continue beyond the first 31 days. If the child is not enrolled within the 31 days, then the rules applicable to *late enrollees*, as described later in this *Certificate, apply*.
- Court-Ordered Guardianship - A court newly-orders an *eligible dependent* under *your* legal guardianship. The date of status change is the date the court order is issued
- A child who marries or reaches the *dependent* age limit **-** *Coverage* for *your eligible dependent* child will end without notice when *your eligible dependent* marries or reaches the limiting age as described on the cover page of this *Certificate*. If your dependent loses coverage due to dependent age limits and/or marries and you wish to continue coverage under the Young Adult Coverage

Rider, once that child meets the definition of *Young Adult* you must notify your employer that you wish to obtain the Young Adult Coverage Rider within 31 days of the dependent reaching the limiting age.

NOTE: If both parents are *subscribers*, only one parent can enroll the child as an *eligible dependent*. No one will be refused enrollment or re-enrollment because of: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of violence; or disability.

A *subscriber* and a *spouse* working for the same *Group* cannot be both *subscriber* and *dependent.*

The requirements of this *Certificate* will apply equally to *you* and to *your* enrolled *eligible dependents*, except when there is a change in *your* family status as described above.

All benefits and privileges made available to *you* shall be available to *your* enrolled *eligible dependents* except for:

- *eligible dependent* children who marry may not enroll their *spouses* and they cease to be eligible for *coverage* as an *eligible dependent;*
- when required by law, a minor *dependent* may not convert to *Individual Conversion Contract*, other than as an *eligible dependent* of an adult *subscriber*.

***Late enrollee*s -** A *late enrollee* is a *subscriber* or *eligible dependent* who did not request enrollment in *ADVANTAGE*:

- During the initial enrollment period in which he/she was first entitled to enroll; or
- During any special enrollment period, as provided in this *Certificate*.

The term "*late enrollee*" does not include:

- A *subscriber* or *eligible dependent* who:
  - was covered under another health insurance *carrier* or had other health insurance at the time *ADVANTAGE* was previously offered to him/her; and
  - requests enrollment within 31 days after losing that other health insurance due to:
    - exhausting his/her COBRA benefits;
    - loss of eligibility for the other health insurance, including as a result of legal separation, divorce, death, termination of employment, or reduction in work hours;
    - termination of *Group* contributions toward other health insurance.
- A *subscriber* who:
  - is employed by an *Group* that offers multiple health insurance *carriers*; and
  - elects a different *carrier* during an *open enrollment period*.
- A *subscriber* and his/her *spouse*, minor child, or *eligible dependent* child, when:
  - a court orders that health insurance for the *spouse*, minor child, or *eligible dependent* child be provided under *ADVANTAGE*; and
  - enrollment is requested within 31 days after the order was issued.
- A child under age 18, when a court orders the *subscriber* or an *eligible dependent* to provide health insurance for the child.
- A *young adult*

A *late enrollee* may request enrollment at any time. The *coverage* will become *effective* on the next *renewal date* or at the end of 12 months after the date enrollment is requested; whichever occurs first.

Special Enrollment Periods

If *you're eligible dependent* or a *young adult* did not enroll with *ADVANTAGE* when *you* enrolled due to other *coverage*, and that *eligible dependent* has since lost the other *coverage*, *your eligible dependent* or *young adult* does not have to wait until *your Group's* next *open enrollment period*. They are entitled to a special enrollment period.

- *You* must request a special enrollment period within thirty (30) days from the date *your eligible dependent* loses the other *coverage*.
- If *your eligible dependent's* other *coverage* is through COBRA, special enrollment can only be requested after the COBRA continuation *coverage* is exhausted (Refer to the <u>Continuation of *Coverage* Section</u> of this *Certificate* for an explanation of COBRA *coverage*).
- Special enrollment period can only be requested after losing eligibility for the other *coverage* or after *Group* contributions have stopped.

An employee who loses *coverage* is effective on the first day of the month following the date the employee submits the election form to the *Group*.

Special enrollment period also occurs if *you* have a new dependent by birth, marriage, adoption or placement for adoption. If *you* are an *ADVANTAGE subscriber*, *your* newly acquired *spouse* may become enrolled with *ADVANTAGE* by the first of the following month. If *you* are an eligible employee and not an *ADVANTAGE subscriber*, *your* newly acquired *spouse* can be enrolled together with *you* when *you* marry or when a child is born, adopted or placed for adoption. A child who becomes *your dependent* as a result of marriage, birth, adoption or placement for adoption can be enrolled if *you* enroll at the same time. Refer to the Enrollment, Eligibility and *Coverage* Information section of this *Certificate*. The election to enroll newly acquired dependents under special enrollment must be made within thirty (30) days following the birth, marriage, adoption, or placement for adoption.

If you are an eligible employee who is an ADVANTAGE subscriber you are not eligible for "special enrollment." However, your new spouse, newborn or newly adopted child is eligible for special enrollment. These new dependents must be enrolled in the same product option in which you are currently enrolled.

What do I do if my name or address changes?
If *your* name or address changes, it is very important that *you* notify *your Group* as soon as possible. *Your Group* will notify *ADVANTAGE*, at which time, *your* records will be updated.

Other Rules of Enrollment

Service area
ADVANTAGE defines *service area* as the 30 air mile radius surrounding the *PCP* selected by *you*. With the exception of a full-time student as described in this *Certificate*, *you* and *your eligible dependents* must select a *participating PCP* within 30 air miles of *your* permanent residence or place of employment. If *you* change *your* permanent residence or place of employment, and *you* no longer live or work within a 30 mile radius of *your* assigned *PCP*, *you* must select a new *participating PCP*. If there is no *participating PCP* in the *Provider Directory* available within 30 air miles of *your* new residence or place of employment, then *you* should contact *your Group* to determine if other *coverage* is available. An absence from the *service area* for more than ninety (90) consecutive days will be considered a change in permanent residence, unless otherwise indicated by *your Group*. *You* must notify *ADVANTAGE* of any move or extended absence from the *service area*. Failure to notify *ADVANTAGE* of a move or extended absence may result in *your* having to pay for services obtained outside of the *service area*. Should *you* have questions regarding *service area* requirements, please contact *ADVANTAGE*'s Member Service Department.

Non-Custodial Parent
Whenever a child of a non-custodial parent has *coverage* with *ADVANTAGE*, the custodial parent may receive information that is necessary for the child to obtain *covered services*. However, *ADVANTAGE* will not be obligated to provide information to the custodial parent unless *ADVANTAGE* is provided with the correct address. The custodial parent will be entitled to submit claims to *ADVANTAGE* or the *provider network* for payment to be made to *providers* for *covered services*.

SECTION 4: *COVERED SERVICES* – BENEFITS

Each *covered services* category is shown with any applicable *copayment, deductible, or coinsurance* for which *you* are responsible to pay at the time of service. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions explained in this *Certificate*, including any attachments. All *copayments, deductibles* and *coinsurance* in effect at the time of service will apply to all *covered services*. **Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate*.**

You are entitled to the *covered services* listed in this section when those services meet the following criteria:

- Services are *medically necessary*; and
- Services are provided or *authorized* by *your PCP*; and
- Services are not excluded elsewhere in this *Certificate*
- Except for *emergency services* and services otherwise *authorized* by *your PCP*, all *covered services* must be obtained from *participating providers.*

Prior *Authorization*

Certain services require prior *authorization* before obtaining those services. For a list of services that require prior *authorization* please refer to *your* Member Reference Guide, contact *ADVANTAGE* Member Services Department by phone or log onto www.advantageplan.com via the internet. *Member* is responsible for obtaining all prior *authorization*s as indicated in the Member Reference Guide.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Allergy Tests and Procedures		
• Serum		50% *coinsurance*
• Administration of serum	Refer to *Physician* Services benefit	Refer to Physician Services benefit
• Allergy testing	Refer to *Physician* Services benefit	Refer to Physician Services benefit

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Ambulance* Transportation**		
Ambulance transportation is covered for *emergency service*. Other *medically necessary ambulance* transport is covered when *authorized* and ordered by *your PCP* (*ambulance*, medi-van or similar medical ground, air or water transport to or from the *hospital* or both ways). Transfer from a *hospital* to a lower level of care is covered only when *medically necessary* and *authorized* by *your physician*. The *medically necessary ambulance* transport *coinsurance* applies to each transport. *Coinsurance* waived if transferred from one acute *inpatient* facility to another.		20% *coinsurance* per transport (*Coinsurance* is waived if transferred from one acute *inpatient* facility to another)

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Behavioral Health		
All Behavioral health services require an authorization from *your* assigned *behavioral health network*. *You* may access those services directly by calling the Mental Health telephone number listed on *your ID card*. When *you* call this number, identify *yourself* as an *ADVANTAGE member* and *you* will be assisted. *You* will be asked for specific information in order to provide *you* with *authorization* to the appropriate behavioral health services and *participating providers*.		

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
ADVANTAGE ensures *you* can obtain behavioral health services in a timely manner. The *ADVANTAGE* appointment standards for behavioral health care are: • Routine office visits within 10 business days • Initial non-urgent appointments within 10 business days • Urgent appointments within 24 hours • *Emergency* Care is immediate		
Mental Health Services *Option*:		
• *Inpatient psychiatric hospital* services, including evaluation and treatment in a psychiatric day treatment facility, when *medically necessary*, ordered by *your* designated behavioral health *provider* for mental health services and *authorized* by the *behavioral health network*. Limited to 2 *copayments* per *calendar* year.	$250 *copayment*	
• *Outpatient visits* will be provided when *medically necessary* and ordered by *your* designated behavioral health *provider*. *Copayment* applies to both individual therapy and Group therapy sessions.	$35 *copayment*	
• *Partial hospitalization* Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.	$125 *copayment*	
Substance Abuse Option:		
Covered services are provided without limits when treatment of substance abuse and chemical dependency services are required in the treatment of mental *illness*.		
Detoxification for *alcohol* or other drug addiction is covered on an *inpatient* and/or *outpatient* basis, whichever is determined to be *medically necessary*. To be covered, services must be *authorized* by *your* designated *behavioral health network*. *Covered services* are subject to the limitations listed below: • The treatment setting, e.g., *inpatient, outpatient*, residential or transitional, for the treatment of alcohol or other drug dependency shall be determined by your *behavioral health network* designated by *ADVANTAGE* in accordance with *medical necessity*. • The number of rehabilitation days covered represents the days per Contract year of *inpatient* or intensive *outpatient* daycare. Depending on the level of care *medically necessary* for the treatment of alcohol or other drug dependency, covered *inpatient* days will be counted against the rehabilitation day limitations as follows: – One (1*) inpatient* day = one (1) residential day – One (1) extended day *outpatient* treatment = one half *inpatient* day		
• Uniformed *Inpatient* Substance Abuse Services: Limited to 30 days per *calendar* year. Additional 30 days available at 50% *coinsurance*. Lifetime maximum of 2 detoxification admissions.	$250 *copayment*	
• Non-Uniformed *Inpatient* Substance Abuse Services: Limited to 14 days per *calendar* year. Lifetime maximum of 2 detoxification admissions.	$250 *copayment*	
• *Outpatient* Substance Abuse Services: Limited to 20 visits per *calendar* year.		50% *coinsurance*
• *Partial hospitalizations*: Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.	$125 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Pervasive Development Disorder		
Pervasive Developmental Disorder means a neurological condition, including, but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. *Coverage* for services will be provided as prescribed by the insured's treating *physician* in accordance with a treatment plan. Any exclusion within the policy, *Certificate*, or C*ontract* that is inconsistent with the treatment plan does not apply. The benefits for pervasive developmental disorder will not be subject to dollar limits, *copayments*, *deductibles*, or *coinsurance* provisions that are less favorable than the dollar limits, *copayments*, *deductibles*, or *coinsurance* provisions that apply to physical *illness* generally under the accident and sickness insurance C*ontract.*	Included in *physician* office visit *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Corrective Appliances and Prosthetics		
Corrective appliances and prosthetics must be *medically necessary* and used to restore function or to replace body parts. They must be provided with a *proper referral* and as prescribed by the *participating physician*. Examples of corrective appliances include, but are not limited to • Pacemakers • Hemodialysis equipment • Breast prostheses • Prosthetic limbs • Back braces • One pair of eyeglass lenses following cataract surgery not to include tinting, scratch-proofing or transitioning. • Ostomy supplies *Covered services* include the purchase, replacement or adjustment of artificial limbs or eyes, when required due to a change in *your* physical condition or body size due to normal growth.		50% *coinsurance*

What are the *non-covered services* or limitations?

- Appliances and aids which are not necessary for the restoration, function or replacement of a body part.
- Non-durable appliances.
- Hearing aids.
- Dental appliances.
- Dentures.
- Foot Orthotics

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate.*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Dental – Limited *Covered services*		
Medical services related to *injury* to sound and natural teeth when *injury* is reported immediately, and treatment must be sought with proper referral to a *participating provider* within a 72-hour period. *Injury* must be traumatic (an *injury* to living tissue caused by an extrinsic agent) or caused by the force of an external object striking the tooth. After *emergency* treatment, follow-up care must be obtained from a *participating provider* upon a *proper referral* from the *PCP* and initiated within sixty (60) days of the *injury*. All treatment must be completed within one year from the initiation of treatment and accident must have been incurred on or after the *effective date of coverage*	$35 *copayment*	

Hospital and anesthesia services related to dental care are covered if:

- *You* are under age 19, or *you* are 19 or older and have a record of, or are regarded as having, a physical or mental impairment that substantially limits one or more of your major life activities; and
- *Your* mental or physical condition requires that dental care be provided in a *hospital* or *outpatient* surgical center.

The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the standards for determining whether performing dental procedures necessary to treat the individual's condition under general anesthesia constitutes appropriate treatment.

The dental procedure is excluded from *covered services*. The "*Inpatient Hospital* Services" *copayment or coinsurance* will apply to *inpatient* services. The "Outpatient Surgical Services" *copayment or coinsurance* will apply for *outpatient* services in a *provider network hospital* or *provider network outpatient* facility.

What are the other *non-covered services* or limitations?

- Injured teeth must be sound and natural, including teeth that have been filled, capped, or crowned
- Accident must have been incurred on or after the *effective date of coverage* with *ADVANTAGE*
- All unauthorized services, or services rendered by a non-*participating provider* are *non-covered services*
- All services not completed within one year from initiation of treatment are *non-covered services*
- Repair of *injury* caused by an intrinsic force, such as the force of the upper and lower jaw in chewing, are *non-covered services*
- Repair of artificial teeth, dentures or bridges are *non-covered services*

Please refer to Section 5*, Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate*.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Diabetes Self Management Training		
Covered services are limited to • *Physician* authorized visit(s) after receiving a diagnosis of diabetes • *Physician* authorized visit(s) after receiving a diagnosis that represents a significant change in *your* symptoms or condition and there is a *medically necessary* change in *your* self-management • *Physician* authorized visit(s) for re-education or refresher training		
Diabetes self-management training	No *copayment*	No *coinsurance*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Dialysis		
Outpatient or *inpatient* dialysis services with a *proper referral* and provided by a *participating provider*.	$0 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Durable medical equipment (DME)		
Rental or purchase of *DME*, including all durable and non-durable supplies required to operate the *DME* and are integral to the *DME* set-up. The following *covered services* apply if there is a *proper referral and:* • When *medically necessary* • When equipment can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of *illness* or *injury* and is suitable for use in *your* home. Examples of *DME* include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, *hospital* beds, monitoring devices, oxygen-breathing apparatus, and insulin pumps. • Training in the use of any *medically necessary* covered *DME* is also covered, when so authorized Rental payments apply to purchase of equipment		50% *coinsurance*

What are the *non-covered services* or limitations?

- Equipment that cannot withstand repeated use.
- Equipment that is not medical or not primarily and customarily used to serve a medical purpose; equipment that serves as useful in the absence of illness or injury.
- Equipment that is not suitable for use in the home.
- You are entitled only to the basic type of DME necessary to provide for your medical needs as determined by your physician and authorized by ADVANTAGE.
- Items and equipment specifically fitted to an individual and not appropriate for repeated use by multiple patients.

Examples of non-covered items: corrective shoes; arch supports; hearing aids; dental prostheses; deluxe equipment; common first aid supplies; and non-durable supplies which are not required to operate a durable medical device and are not an integral part of the *DME* set-up.

Please refer to Section 5*, Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Emergency services and Urgent care		
An emergency service means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to: • place an individual's health in serious jeopardy; • result in serious impairment to the individual's bodily functions; • or result in serious dysfunction of a bodily organ or part of the individual. Examples include, but are not limited to, heart attacks, strokes, poisonings, severe bleeding and convulsions.		
Emergency Room: Includes all related services *Copayment* waived if admitted	$125 *copayment*	

What should I do first?
If *you* feel *you* have a medical *emergency*, and if there is time, *you* are encouraged to call *your PCP* for advice and instructions. *Your PCP* may direct *you* to a *hospital emergency* room or *urgent care* center, or *your PCP* may be able to see *you* in the office. If a medical *emergency* is so serious that in the absence of immediate medical attention it could be life-threatening or cause serious disability or significant jeopardy to *your* health, go immediately to an *emergency* facility or call 911.

What do I do if I need follow-up care?
If *you* receive *emergency services* or *urgent care* services, *you* should contact *your participating provider*'s office within 48 hours or as soon as reasonably possible after *you* receive the services to allow *your PCP* to arrange follow up treatment.

Notice to the *PCP* allows the *PCP* to be informed of *your* condition and, once *you* are stabilized, to coordinate *your* care. In the case of a non-*participating hospital*, contact ADVANTAGE as soon as possible. ADVANTAGE and your attending physician may direct *your* transfer to a *hospital* in the *provider network* once *your* health condition has been stabilized.

To "stabilize" means to provide medical treatment to an individual in an *emergency* as may be necessary to assure, within reasonable medical probability that material deterioration of the individual's condition is not likely to result from or during any of the following:

- The discharge of the individual from an *emergency* department or other care setting where *emergency services* are provided to the individual;
- The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility;
- The transfer of the individual from a *hospital emergency* department or other *hospital* care setting where *emergency services* are provided to the individual to the *hospital's inpatient* setting.

What if I need *emergency services* while I am outside the *service area*?
If *you* become *ill or injured* while *you* are temporarily away from the *service area*, *ADVANTAGE* will cover care for *emergency services* and *urgent care*. If you are hospitalized outside of the service area, contact ADVANTAGE as soon as you are able. If *you* have any questions about how to obtain medical services when *you* are out-of-area, please call the *ADVANTAGE* Member Services phone number listed on the back of *your ID card*. If there is time, *you* should try to call *your PCP* for advice and instructions.

Always remember. . .

- *You* are encouraged to call *your PCP* to arrange for *emergenc*y care if there is time.
- Be sure to contact *your participating* provider within forty-eight (48) hours after receiving *emergency care*.
- If *you* use the *emergency* room or urgent care for non-*emergency* care that is not *properly referred* and *authorized*, you will be responsible for the entire cost.
- If *you* are admitted following *emergency* care, you must contact ADVANTAGE or *your PCP* (or someone may contact *your PCP* on your behalf) **within forty-eight (48) hours** of admission or when you are medically able to do so. If the *member* is a minor, the parent or guardian must contact the *PCP*. If *you* are admitted to the *hospital* directly from the *emergency* room, *your copayment* is waived for the *emergency service*.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Urgent care: includes related services and after hours and *physician* home visits.		
• In-area	$50 *copayment*	
• Out-of-area	$50 *copayment*	

Remember, *urgent care* is determined by medical condition, not the place of service. *Urgently needed services* or *urgent care services* are instances when *you* need *covered services* urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen illness or injury;
- while outside of the service area; or
- for which treatment cannot be delayed until you return to the service area without your condition growing much worse.

If *you* have an *urgent* medical problem that is not an *emergency*, but needs timely attention, simply call *your PCP's* office, even if *you* are out of the *service area*. *Your PCP* knows *your* medical history and will be in the best position to evaluate *your* needs. *You* may be directed by *your PCP* to an *urgent care* center or *emergency* room. Please follow *your* PCP's instructions to ensure services are covered.

An *urgent care* center is a medical facility, where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive *urgent care services*. *Coverage* for *urgent care* includes after hours and *physician* home visits.

As explained in this Section, if *you* receive *emergency services* or *urgent care services*, *you* must contact ADVANTAGE or *your PCP's* office within 48 hours or as soon as reasonably possible after *you* receive the services.

- **Full time students are covered for *emergency services* or *urgent care* while they are outside the *service area*. However, all follow-up care and care that is not considered *emergency services* or *urgent care* under this *Certificate* must be *properly referred* and *authorized* by the student's *PCP* to receive *covered benefits*.**

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Health Education		
Health education provided by the *PCP* as part of preventive health care and other health education classes approved by *ADVANTAGE*. Classes in nutrition or smoking cessation will be approved up to three (3) visits when referred by *your physician.*	No *copayment* applies to health education provided by the *PCP* as part of preventive health care.	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Home Health Services		
Medically necessary home health services with a *proper referral*, including: • Skilled medical services. If continuous medical or skilled nursing services are required, *ADVANTAGE* may require transfer to a *SNF* or other facility if medically appropriate and more cost effective. • Nursing care given or supervised by a *Registered nurse (RN).* • Nutritional counseling furnished or supervised by a registered dietician. • Home hospice services. • Home health aides • Medical supplies, laboratory services, drugs, and medicines prescribed by a *physician* in connection with home health care. • Medical social services. • Training of family members or significant other to provide those *home health services* that can be performed by laypersons.	$0 *copayment*	

Services are considered *covered services* only if they are not considered *custodial care* and the services are prescribed in writing by a *participating physician:*

- As *medically necessary* for the care and treatment of *your illness* or *injury* at home;
- As being in place of *inpatient hospital* care or a convalescent nursing home that would be required in the absence of such services; and
- The services are furnished to *you* while under a *participating physician's* care.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Hospital Care (*Inpatient* and *Outpatient* Medical and Surgical)		
Inpatient Hospital Services: *Inpatient biologic/biopharmaceutical medications* do not require additional *copayment or coinsurance*. Copayment limited to 2 inpatient admissions per calendar year.	$250 *copayment* per admission after deductible (waived if re-admitted within 24 hours of discharge)	
Outpatient Surgical Services: *Outpatient* surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia.	$125 *copayment after deductible*	

What do I do when I need to be *hospital*ized?
Your physician will arrange *your* admission to a *hospital* in the *provider network.*

How do I select a *hospital* or *outpatient* facility?
- When *you* select a *PCP, you* agree to utilize the *hospitals* and facilities in *your PCP's provider network.*

What are the *covered services*?
The *inpatient* and *outpatient* medical and surgical *hospital* services are covered when *medically necessary* and *prior authorized*, by *ADVANTAGE.*
- *Inpatient* medical and surgical services;
- Semi-private room and board (Private room provided when *medically necessary*);
- Intensive Care Unit/Coronary Care Unit;
- *Inpatient* cardiac rehabilitation, limited to annual maximum of 90-days;
- *Inpatient* rehabilitation therapy which includes physical, occupational, speech and pulmonary of acute *illness* or *injury* to the extent that significant potential exists for progress toward a previous level of functioning limited to an annual maximum of 90 days.
- *Outpatient* medical and surgical services, including those diagnostic invasive procedures, which may or may not require anesthesia;
- Other *medically necessary inpatient hospital* services, including but not limited to: general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in *hospital*; laboratory and x-ray examinations; electrocardiograms; and special duty nursing (when requested by a *physician* and certified as *medically necessary*).
- *Inpatient* biologic/biopharmaceutical medications do not require additional *copayment* or *coinsurance*.

Medically necessary professional services for surgical operations (major and minor), include but are not limited to:
- Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a *member* (if services begin within one year of the accident);
- Replacement of diseased tissue surgically removed while a *member*;
- Treatment of a birth defect in a Dependent child;
  ADVANTAGE is a health maintenance organization responsible for arranging for the provision of *covered services* under *your* benefits. Federal law requires health *carriers* that provide medical and surgical benefits for mastectomies to also cover reconstructive surgery and other related services following a mastectomy. Under the law, if a *member* has a mastectomy and, in consultation with the *physician*, elects to have reconstructive surgery, the *covered services* would include:
  - Reconstruction of the breast upon which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications at all stages of mastectomy, including lymphedemas.
- The manner of treatment for any given patient is to be decided in consultation with the attending *physician* and patient. The law permits *copayments, coinsurance and deductibles* to apply.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Infertility diagnostic testing up to diagnosis of infertility only, and infertility counseling:		
For *medically necessary* treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies for the reproductive system	$35 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Injections (Therapeutic) and Infusion Therapy:		
Outpatient therapeutic injections which are *medically necessary* and which may not be self-administered. Injections include, but are not limited to chemotherapy, antibiotics, analgesics, hydration, total parenteral nutrition (TPN), Prolastin, and Factor 8 injections, which are *medically necessary*. Self-injectables are *covered services* only when authorized by *ADVANTAGE*. *Biopharmaceutical Drugs* are subject to the *copayment* or *coinsurance* indicated.		
Therapeutic injections and infusions (non-*Biopharmaceutical drugs* or insulin drugs):	$0 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Maternity Care		
• Professional obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including *physician services*, laboratory and x-ray services as *medically necessary* and appropriate.		
	One time copayment of: $20 initial visit (PCP)	
	One time copayment of: $35 initial visit (PCP)	

Please refer to "Hospital Care" for inpatient benefits

The benefits include *physician* services, *hospital* services, and laboratory and x-ray services as *medically necessary* and appropriate.

After a normal, vaginal delivery, a woman and her newborn child may stay in the *hospital* for a minimum of 48 hours. After a Cesarean section, a woman and her newborn child may stay for a minimum of 96 hours. A shorter length of stay is included in *covered services*, if: the woman and attending *physician* agree that the woman or newborn child does not need further *inpatient* care; in the attending *physician*'s opinion the newborn meets the criteria for medical stability under the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines; and an "*at home post delivery care*" visit is provided.

Unplanned interruption of pregnancy (miscarriage) will be treated as any other *illness*, including, but not limited to *medically necessary physician's* services, *hospital*izations, x-ray and laboratory services.

Always remember…
You MUST make an election to enroll the newborn within the first 31 days of birth for *coverage* to continue past the 31st day.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Medical Social Services		
Hospital services to assist *you* and *your* family in understanding and coping with the emotional and social problems affecting health status. There is no copayment for this covered service.	$0 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Medical Supplies		
Casts, dressings, splints, and other devices used for reduction of fractures and dislocations. There is no *copayment* for this covered service	$0 *copayment*	

What are the *non-covered services*?
Non-durable supplies and/or convenience items are not covered.

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate.*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Morbid Obesity *Option*		
Morbid Obesity means: • A body mass index of at least thirty-five (35) kilograms per meter squared, with co-morbidity coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or • A body mass index or at least forty (40) kilograms per meter squared without co-morbidity.		
Non-surgical Treatment for Morbid Obesity		
As an alternative to surgical treatment for *morbid obesity*, *ADVANTAGE* will pay for enrollment in an in-network *physician*-supervised weight loss treatment program when referred by your physician and authorized by *ADVANTAGE*.	Enrollment fees in excess of $50 after $35 *copayment* per visit. Maximum of 6 visits per *calendar* year.	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Newborn Examinations		
Newborn examinations are covered under maternity care, or *hospital* care, or *physician* office visits.	No additional *copayment*	
Newborn examinations include the detection of: • *Inherited Metabolic Disease* includes services for *medical food* and *low protein modified food products*, (not subject to *copayment*, regardless of supplier) as defined in the Glossary of Terms. • Hypothyroidism • Hemoglobin paths, including sickle cell anemia • Galactosemia • Maple Syrup Urine Disease		

- Homocystinuria
- Inborn errors of metabolism that result in mental retardation and that are designated by the State Health Department
- Physiologic hearing screening examinations for detection of hearing impairments

If a parent of an infant objects in writing, for reasons pertaining to religious beliefs only, the infant is exempt from the examinations.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Outpatient* Services**		
Outpatient Services including but not limited to: laboratory, pathology, radiology ;		
Services in *PCP* or *SCP* office	Included in office visit *copayment*	
Services in other *outpatient* setting	$0 *copayment after deductible*	
Electrocardiology (EKG) and electroencephalography (EEG),	$0 *copayment*	
MRI, CT, MRA, SPECT and PET scan	$0 *copayment after deductible*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Physician* Services – Office visits for the treatment of *illness* or *injury		
Office visit Services:		
• *Primary care physician* Office Visit	$20 *copayment* per office visit	
• Specialty and Referral *Physician* Office Visit	$35 *copayment* per office visit	

- Office visits, services and supplies for the determination and/or treatment of *illness* or *injury*. These services include medical consultations, and procedures performed in the *physician*'s office, *second opinion* consultations, and specialist treatment services.
- Allergy Testing
- Diabetes self-management training
- Maternity care – refer to Maternity Care benefit

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Physician* Services – Non-Office Visit Services**		
• *Primary care physician*, Specialty and Referral for all *Physician* Services in the *Hospital* or *Outpatient* Facility	$0 *copayment*	
• *Primary care physician*, Specialty and Referral *Physician* visits in the Home when provided by *your participating physician*	$50 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

***Physician* Services for wellness and preventive services**

The following services will be included in the office visit *copayment* when services are performed in the *physician* office. Services performed outside of the *physician* office will not have a *copayment*.

Included in the *physician* office visit *copayment*

Provided by the *PCP* or other authorized *provider* including, but not limited to:

- Routine physical exam – Periodic health appraisal examinations for *members* who are less than 18 years of age for the prevention and detection of disease as recommended by the American Academy of Pediatrics. For *members* age 18 and older, history and periodic health evaluations (physical examinations for the prevention and detection of disease) limited to the extent *medically necessary* or appropriate.
- Routine total blood cholesterol screening
- Colorectal Cancer screening – Colorectal cancer examinations and laboratory tests, as mandated by Indiana State Law, must be covered for any non-symptomatic individual in accordance with current American Cancer Society Guidelines for a covered person who is:
  a) at least fifty (50) years of age; or
  b) Less than fifty (50) years of age and at high risk for colorectal cancer.

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine gynecological services
- Routine mammographies – Breast cancer screening tests as mandated by Indiana State Law, include;
  a) One (1) baseline screening mammography before the age of forty (40) for a *member* who is at least thirty-five (35) years old;
  b) Annual screening mammography if at risk and less than forty (40);
  c) Annual screening mammography for *members* forty (40) years old and older;
  d) Any additional mammogram views needed for proper evaluation and ultrasound services; if *medically necessary.*

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine Prostate Specific Antigen (PSA) Test as mandated by Indiana State Law, include;
  a) At least one (1) PSA test annually for an individual who is at least fifty (50) years old;
  b) At least one (1) PSA test annually for an individual less than fifty (50) who is at high risk of prostate cancer according to the American Cancer guidelines.

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine immunizations- Immunizations and inoculations (vaccine and administration of vaccine) based on the guidelines of the Advisory Committee on Immunization Practices (ACIP) or at *ADVANTAGE*'s discretion, other nationally recognized organizations, such as the American Academy of Pediatrics (AAP) or the Academy of Family *Physician*s (AAFP).
- Hearing tests – Hearing examinations,as mandated by Indiana State Law, including an infant physiological hearing screening examination at the earliest feasible time for the detection of hearing impairments.
- Vision screening

PHARMACY SERVICES

Outpatient Prescription Drug *Option*

All *covered services* for *outpatient* prescription drugs will be subject to inclusion on the *formulary* and a mandatory generic requirement. This means when the *member* or *physician* chooses a *brand-name drug* instead of the available *generic*, the *member* must pay the higher *copayment or coinsurance* plus the cost difference between the *brand* and the *generic*. You must satisfy the outpatient prescription drug *deductible.*

All prescriptions must be prescribed by a *participating provider* in order to receive this *covered service*. *ADVANTAGE* requires that all prescriptions be filled with the most cost-effective *generic* medication, if available, and approved by the Food and Drug Administration (FDA) for the prescribed indication, dosage and administration, and subject to the limitations and exclusions described in this Section. *Covered services* include: all drugs requiring a prescription either by State or Federal law, except injectables (other than insulin); All compound prescriptions that contain at least one covered prescription ingredient; and insulin and insulin needles and syringes, when prescribed by a *participating*

physician and dispensed to you. The quantity dispensed shall be limited to that sufficient to treat acute phase of *illness* or a thirty-(30) day supply, whichever is less, per *copayment or coinsurance*.

Please refer to the cover page of this *Certificate* to determine if *you* have any *deductible* or *Out- of- pocket Maximum* applicable to *your* prescription *covered services.*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Outpatient* Prescription Drug THREE TIER *Option **INCLUDES: DIABETES SUPPLIES (Please refer to the *formulary*)**		
TIER 1 – Preferred Generic Drug When *you* receive a Preferred *Generic drug*, *you* pay the lowest out-of-pocket cost for the prescription.	Retail: $10 *copayment* per prescription up to a 30-day supply Mail Order: $20 *copayment* per prescription up to a 90-day supply	
Tier 2 – Non-Preferred Generic Drug	Retail: $20 copayment per prescription up to a 30-day supply Mail Order: $40 copayment per prescription up to a 90-day supply	
TIER 3 - Preferred *Brand-name drug* If *you* or *your physician* requests a *brand-name drug* when there is a *generic* equivalent available, *you* will be charged the Preferred *Brand-name drug copayment* PLUS the difference between *ADVANTAGE*'s maximum allowable charge for the *generic* and the *brand-name* contract price.	Retail: $30 copayment per prescription up to a 30-day supply Mail Order: $60 copayment per prescription up to a 90-day supply	
TIER 4 -Non-Preferred *Brand-name drug* If *you* or *your physician* requests a *non-formulary brand-name drug* when there is a *generic* equivalent available, *you* will be charged the Non-Preferred *Brand-name drug copayment* PLUS the difference between *ADVANTAGE*'s maximum allowable charge for the *generic* and the Non-Preferred *Brand-name drug* contract price.		Retail: 50% coinsurance per prescription up to a 30-day supply Mail Order: 50% coinsurance per prescription up to a 90 day supply.

What is a *formulary*?
ADVANTAGE utilizes a prescription drug *formulary*. A *formulary* is a list of preferred *generic* and *brand name* prescription medications that have been approved by the Food and Drug Administration (FDA). Each "Tier" is described in the *formulary* document, and *you* may review the most-recent *formulary* by logging onto www.advantageplan.com.

ADVANTAGE has a team of *physicians* and pharmacists who meet regularly throughout the year to review and update the *formulary*. It includes medications for most conditions treated outside the *hospital*. *Your participating physician* will refer to the *formulary* to select medications that are appropriate to meet *your* healthcare needs, while helping *you* maximize *your* prescription drug benefit. *Participating physicians* and pharmacists are provided with information about *ADVANTAGE*'s *formulary* and updates as new medications are approved to be added to the *formulary* or when current medications are replaced.

What is a *generic drug*?
A *generic drug* is a copy of a *brand name* drug for which the patent has expired. The *generic drug* may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the *brand name* drug. The same quality and safety standards that apply to *brand name* drugs also apply to the *generic* form. The FDA sets standards and reviews all *generic* medications before marketed.

What is a *brand-name drug*?
A *brand name* drug is a drug that has been manufactured under a patent and in accordance with the approval for the FDA.

Is prior *authorization* required for *outpatient* prescription drugs?

A limited number of prescription drugs require prior *authorization*. The pharmacist will advise *you* if *your* prescription requires prior *authorization*. *Your* prescribing *physician* is required to complete a "Letter of Medical Necessity" and fax it to the pharmacy benefits manager's *authorization* unit. The information is reviewed for clinical information that would indicate the prescription drug is covered under *your* benefit plan for *your* circumstances. *Participating physicians* have been educated about the prior *authorization* drug process. Many *physicians* will complete the "Letter of Medical Necessity" at the time he/she provides *you* with the prescription.

If the prescription is *authorized* after review, a Member Services Representative will notify *you* as quickly as possible. If *authorization* is denied, a clinical specialist will notify the prescribing *physician* to discuss the clinical guidelines used for the denial, and *you* will be notified of the denial in writing and of *your* right to appeal.

If *you* have questions about the prior *authorization* process for prescription drugs, please contact a Member Services Representative for assistance.

What are the *non-covered services* or limitations?

LIMITATIONS
You will be reimbursed, less the applicable *copayment, coinsurance and deductible*, if applicable for prescription drugs obtained from other than the designated *ADVANTAGE participating pharmacies*, only when the drug was:

- Ordered in connection with an out-of-area *emergency* covered under the *emergency services* section described in this *Certificate* ;
- Ordered by a *physician* for immediate use because of *medical necessity* and because *your* designated pharmacy is not open for business at that time.

Reimbursement in the above two circumstances will be limited to the *Maximum allowable amount* of cost for a quantity of the drug sufficient to treat the acute phase of the *illness* or to a maximum of thirty (30) day supply, whichever is less.

A drug not approved by the FDA may be prescribed if one of the following conditions is met:
- the drug is recognized for treatment of the indication in at least one (1) standard referenced compendium; or
- the drug is recommenced for that particular type of cancer and found safe and effective in informal clinical studies; the results which are published in the United States or Great Britain.

***Covered services* will only be provided in the quantity equal to the amount prescribed for use through the last day of eligibility.**

NON-COVERED SERVICES
- Injectables, which are not listed on the *formulary*;
- Implantable drugs; implantable devices for the administration of drugs;

- Devices and appliances other than insulin syringes/needles (e.g., diaphragms, cervical caps or intrauterine devices (IUDs);
- Drugs administered in *physician's* offices, *hospitals*, nursing homes, *ADVANTAGE* Skilled Nursing Facilities and hospices;
- Except for Nicotine Patches obtained through a prescription, all over the counter (OTC) drugs;
- Drugs whose purpose is the treatment of infertility or impotence; except for drugs approved through the *ADVANTAGE* review process, drugs prescribed that are investigative or *experimental* in nature. A drug shall be considered *experimental* if it has not been approved by the FDA and if the FDA has not approved the drug for the route of administration, the dosage involved, or except as otherwise required by law for certain cancer drugs, the specific indications for which the drug is being prescribed;
- Drugs used for *cosmetic* or recreational purposes (e.g., anabolic steroids, anorexiants, topical minoxidil, or Retin-A for wrinkles, however, retonic acid creams are covered when used in connection with the treatment of severe acne.) Drugs prescribed as part of the treatment for congenital defects or anomalies, shall not be considered *cosmetic* for purposes of this Section;
- Anorexiants, food supplements and other drugs when prescribed for the treatment of obesity;
- *Hospital* discharge drugs; take-home drugs;
- Oral prescription medications when prescribed for foreign travel;
- Replacement of drugs due to loss, theft or negligence;
- Maintenance drugs when filled at a Non-*ADVANTAGE participating pharmacy*;
- Excluded prescriptions may be purchased at a participating *ADVANTAGE participating pharmacy* at *ADVANTAGE*'s negotiated discount price.
- Growth Hormones and related products
- Vitamins and Nutritional Supplements

Where do I get my prescriptions filled?

Retail Pharmacy Locations

ADVANTAGE contracts with Pharmacy Benefit Manager to provide retail prescriptions at the following store pharmacies

- CVS
- Meijer
- Wal-Mart
- Kroger
- Kmart
- Walgreens
- Target
- Marsh

Other local and regional pharmacies may participate in our pharmacy network. *You* can find a complete listing of pharmacies that participate with our network and *ADVANTAGE* by calling 800-553-8933. All prescriptions must be filled through Pharmacy Benefit Manager, or *you* may save money by having *your* refillable prescriptions provided through the Pharmacy Benefit Manager mail order program (see below for more information).

Mail Order Program

Under the Prescription Drug Program, *you* may receive covered maintenance prescriptions through the Pharmacy Benefit Manager approved mail order program. Maintenance prescriptions are those that eligible *members* may receive a savings for up to a maximum 90-day supply per prescription.

You may begin using the mail order prescription program by completing the Mail Order Form provided with *your* new *member* welcome packet (contact an *ADVANTAGE* Member Services Representative if *you* need a Mail Order Form). *You* must call *your physician's* office and request a new prescription for the maximum days supply allowed. Mail *your* new prescription(s) and *your copayment*(s) or *coinsurance* along with the completed form in the envelope attached to the order form. Please allow for an average delivery time of two weeks.

If *you* have questions about the prescription drug benefits, please contact an *ADVANTAGE* Member Services representative for assistance.

Always remember…
Keep *your PCP* informed of medications prescribed by specialty care *providers* or behavioral health *providers* to prevent adverse drug interactions.

Biopharmaceutical Drugs	*COPAYMENT*	*COINSURANCE*
Biopharmaceutical drugs means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. *Biological* or *biopharmaceutical products* typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct *physician* involvement, and significant *member* education. These services must be *authorized* by *ADVANTAGE*. *Coinsurance* applies to drugs dispensed up to a 30 day supply.	$125 *copayment/30-day supply applies PLUS applicable office visit copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Skilled nursing facility/hospice facility:		
Limited to 100 days per "*Benefit period*" as defined by Medicare and in this *Certificate*. Day limits do not apply to hospice.		
*Skilled nursing facility (SNF)/*Extended Care Services, *inpatient* hospice:	$0 *copayment*	

Covered services when *medically necessary* with a *proper referral* include:

- Semi-private room; private room provided when *medically necessary*.
- Drugs, biologicals, medical social services, short term physical, speech, occupational therapies (subject to limitations listed in the Short-term Therapies indicated below) and other services generally provided by skilled nursing facilities.
- Hospice care provided if you are terminally ill, in accordance with a treatment plan developed before your admission to the hospice care program. Treatment plan must include a statement from the physician documenting that life expectancy is six months or less.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Therapies – Short-Term:		
Short-Term Therapies are limited to a combined 60 visits per each distinct condition or episode, or as authorized through a medical management regimen	$35 *copayment*	

Short-term Physical Therapy
Short-term physical therapy – covered with *prior authorization* for a condition that the *physician* believes is subject to continuing improvement.

Short-term Speech and Occupational Therapy
Short-term speech or occupational therapy – services are covered with *prior authorization*, if provided to correct an impairment due to *injury* or *illness*; or a congenital defect.

Covered services for speech therapy when provided to restore speech after a loss or impairment of a previous, demonstrated ability to speak; or develop or improve speech after surgery to correct a defect that existed at birth and impaired, or would have impaired, the ability to speak. ***Covered services* do not include speech therapy due to a delay in speech development.**

Short-term Cardiac Rehabilitation
Short-term services that may be *medically necessary* for the improvement of cardiac disease or dysfunction.

Short-term Pulmonary Rehabilitation
Short term services that may be *medically necessary* for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent *emergency* room visits, progressive dyspnea, hypoxemia, or hypercapnia.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Transplant Services		
Transplants: Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a *member*; Includes a maximum lifetime limit of $10,000 for *covered services* related to transportation and lodging for the donor. The maximum lifetime limit for *covered services* related to transportation and lodging applies to the *policy maximum*. No *coverage* is provided for the donor or the recipient when the recipient is not a *member*. The *inpatient* medical *copayment/coinsurance* applies as specified. The *SCP* office visit *copayment/coinsurance* applies as specified for pre-transplant evaluation. Non-*experimental*, non-*investigational* organ and other transplants are covered. *ADVANTAGE* will cover the donor's medical expenses if the person receiving the transplant is an *ADVANTAGE member* and the donor's expenses are not covered by another health benefit *carrier*.	Applicable inpatient/outpatient *copayment/coinsurance* will apply and, in addition any applicable office visit *copayment/coinsurance* applies for pre-transplant evaluation	Applicable inpatient/outpatient *copayment/coinsurance* will apply and, in addition any applicable office visit *copayment/coinsurance* applies for pre-transplant evaluation

SECTION 5: OTHER *NON-COVERED SERVICES* AND LIMITATIONS ON BENEFITS

The following section indicates the items which are not *covered services* under this *Certificate* and are thus *your* financial responsibility. This information is provided as an aid to identify certain common items which may be misconstrued as *covered services*, but is in no way a limitation upon, or a complete listing of, such items considered not to be *covered services*.

1. Services and supplies that are not performed, arranged, *authorized*, or approved in advance, except as specifically stated in this *Certificate* and/or Member Reference Guide
2. Services and supplies that are not *medically necessary*;
3. Services and supplies that are not specifically listed as covered services;
4. Services not within the scope of the provider's license;
5. Services of a provider who is a member of the patient's immediate family or who normally resides in the patient's household.
6. Services and supplies provided by your family, i.e., parent, brother, sister, or child, or someone who lives with you;

7. Services of a provider treating himself or herself.
8. Services and supplies that are furnished by a government plan, hospital, or institution, unless you are legally required to pay for the service;
9. Services and supplies provided prior to your effective date of coverage or after your coverage is terminated;
10. Services and supplies incurred after *you* leave a program of *inpatient* care for the same condition, against the medical advice of *your physician*;
11. Services and supplies that would have been provided at no cost if you did not have coverage under ADVANTAGE;
12. Services and supplies which are covered, or would have been covered, under any worker's compensation or occupational disease act or law;
13. Except when required by law, services and supplies provided to treat an *illness* or *injury* caused by:
    - any act of declared war;
    - service in the military forces of any country, including non-military units supporting such forces;
    - the commission or attempt to commit a civil or criminal battery or felony; or
    - taking part in a riot ("taking part in a riot" means the use or threat to use, force or violence without authority of law, by four or more persons).
14. All treatments, procedures, facilities, equipment, drugs, devices, services, or supplies that are considered experimental;
15. Cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance, but do not restore or improve impaired physical function (except for services covered in accordance with the Women's Health and Cancer Act of 1998 and services covered for newborns as outlined in Indiana Code 27-8-5.6-2;); wigs;
16. Services and supplies provided to treat hair loss, promote hair growth, or remove hair. However, you are entitled to access ADVANTAGE's discount for such drugs through a participating pharmacy;
17. Orthognathic Surgery
18. Services and supplies related to narcotic maintenance treatment for opiate addiction;
19. Storage of blood products when not medically necessary or not provided in conjunction with a scheduled covered surgery; blood products when replaced by donation;
20. Items or devices primarily used for comfort, including, but not limited to air purifiers, humidifiers, dehumidifiers, whirlpools, air conditioning, waterbeds, exercise equipment, and ultraviolet lighting;
21. Non-skilled care, rest cures, respite care, or domiciliary care, regardless of the setting;
22. Services and supplies provided by your family, i.e., parent, brother, sister, or child, or someone who lives with you;
23. Private duty nursing services provided for the convenience of you or the convenience of your family (for example, bathing, feeding, exercising, moving the patient, giving oral medication or acting as a companion or sitter);
24. Room and board services while you are permitted to temporarily leave a hospital, SNF, or hospice facility;
25. Orthodontia and other dental services, except as expressly provided for in this Certificate or any attachment to this Certificate ;
26. All unauthorized dental services, or services rendered by a non-participating provider; dental appliances; dentures; dental prostheses;
27. All dental services not completed within one year from initiation of covered treatment;
28. Repair of dental injury caused by an intrinsic force, such as the force of the upper and lower jaw in chewing;
29. Repair of artificial teeth, dentures, or bridges;
30. Physical exams and related x-ray and lab expenses, when provided for employment, school, sports' programs, travel, immigration, administrative purposes, or insurance purposes;

31. Pre-marital tests or exams;
32. Other services and/or supplies which are not, in the judgment of your participating physician, medically necessary for the maintenance or improvement of your health;
33. Services and supplies for the treatment of: adult hyperkinetic syndrome, learning disabilities, mental retardation, behavioral disorders, developmental delay or disorder, or senile deterioration, beyond the period necessary to diagnose the condition.
34. Marriage counseling, personal growth therapy, or sex counseling or therapy;
35. Hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders by the American Psychiatric Association;
36. Self-help training and other related forms of non-medical self care, which are unrelated to mental health;
37. Services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction
38. Immunizations provided for the purpose of travel;
39. Supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions, and calluses.
40. Routine foot care except when medically necessary for the treatment of diabetes and lower extremity circulatory diseases.
41. Telephone consultants, charges for completion of claim forms;
42. Fees that the provider may charge you if you miss scheduled appointments without canceling with reasonable notice;
43. Chiropractic services;
44. Court-ordered services, unless appropriate, medically necessary, and authorized by your physician;
45. Travel or hospitalization for environmental change, or physician services connected with prescribing environmental changes;
46. Naturopathic medicine or Christian Science medicine;
47. Acupuncture, except where administered by a participating provider and used as an anesthetic agent for covered surgery;
48. Preparation of special medical records or court-ordered appearances for hearing or proceedings;
49. Medical care provided outside the U.S., unless an emergency;
50. Massage Therapy
51. Except for physician-supervised programs referred by your physician and authorized by ADVANTAGE, services, drugs, and supplies for weight loss, diet, health or exercise programs, health clubs dues, or weight reduction clinics. However, you are entitled to access ADVANTAGE's discount for such drugs through a participating pharmacy;
52. Vision examinations, refractions, eyeglasses and contact lenses and their fitting; Eyeglass lenses unless medically necessary following cataract surgery; refractive surgery performed to treat myopia or hyperopia;
53. Contact Lenses unless: medically necessary for the treatment of Keratoconus; or medically necessary for intraocular implant of lenses for Aphakia or after cataract surgery;
54. Non-prescription glasses or vision devices; orthoptics or vision therapy including eye exercises and any associated supplemental testing;
55. Services or supplies for, or related to:
    - sex change operations or reversal, except for congenital deficiency;
    - artificial insemination
    - gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in-vitro or in-vivo fertilization;
    - abortion;

- voluntary sterilization or reversal of sterilization;
- birth control drugs, supplies, or devices; however, *you* are entitled to access *ADVANTAGE's* discount for such drugs through a *contracting pharmacy*;
- use of a surrogate for any reason

56. Hearing aids, Hearing therapy, or cochlear implants and their fitting

57. Audiometric exams for the purpose of hearing aids.

58. Treatment of temporomandibular joint (TMJ) disorder;

59. Extensive long-term neuromuscular rehabilitation, i.e., physical, speech or occupational therapy is excluded. Rehabilitation that the physician reasonably believes will require in excess of 60 days per each distinct condition or episode, beginning with the first rehabilitation treatment for that condition, will be considered "long-term" and is not covered. (When you undergo a rehabilitative treatment for a specific and distinct condition, that visit constitutes one treatment). *ADVANTAGE* reserves the right to extend *covered services* through a formal medical management regimen.

60. Personal comfort items, including but not limited to services and supplies not directly related to *your* care, such as guest meals and accommodations, private room (unless *medically necessary*), personal hygiene products, telephone charges, travel expenses (other than approved *ambulance* services as provided in the basic health services), take-home supplies including prescription drugs and similar items;

61. Service obtained by a *member* from *physicians*, *hospitals* or other *providers* not associated with *ADVANTAGE*, either within the *service area* or outside the *service area* (except *emergency services* or upon proper referral by a *participating physician*);

62. Recreational or educational therapy;

63. Treatment and testing for adolescents and children, which are state mandated services by or of the school system, unless therapy is deemed *medically necessary* by a *participating provider*;

64. Court ordered therapy, unless appropriate, *medically necessary*, and *authorized by your participating behavioral health provider*;

65. Vocational therapy, including work hardening programs;

66. Newborn deliveries performed by a midwife in the home and any charges, including but not limited to supplies and equipment as a result of such deliveries.

67. Treatment or services related to *pre-existing medical condition* which are incurred during the *pre-existing medical condition exclusion period* as defined in this *Certificate*

68. Growth Hormones and related products;

69. Services and supplies for the treatment of alopecia and/or alopecia areata;

70. Corrective appliances and artificial aids which are not necessary for the restoration, function, or replacement of a body part; non-durable appliances;

71. Speech therapy due to a delay in speech development;

72. Common first aid supplies;

73. *Durable medical equipment* that:
    - cannot withstand repeated use;
    - is not medical or not primarily and customarily used to serve a medical purpose;
    - serves as useful in the absence of *illness* or *injury*;
    - is not suitable for use in the home;
    - specifically fitted to an individual and not appropriate for repeated use by multiple patients;
    - is considered deluxe equipment. *Covered services* are only for the basic type of *DME* necessary to provide for *your* medical needs as determined by *your physician* and authorized by *ADVANTAGE*.

74. Non-durable supplies and/or convenience items which are not required to operate a durable medical device and are not an integral part of the *DME* set-up;

75. Non-durable medical supplies for use outside the *hospital* or *physician* office;

76. Surgical treatment of *morbid obesity*;

77. Maternity services when *member* is acting as a surrogate mother.

78. Treatment or services related to *pre-existing medical conditions* which are incurred during the *pre-existing medical exclusion period* as defined in this *Certificate.*

79. Services and supplies provided after *Policy maximum* has been exceeded by the *member.*

80. Medical care for a *preexisting medical condition* of a *Young Adult* until six (6) months after the effective date of the *Young Adult's* coverage with *ADVANTAGE*. This *preexisting medical condition* limitation period will be reduced by the number of days of *prior creditable coverage* the *Young Adult* has at the time of enrollment. The *preexisting medical condition* limitation does not apply to:
    (1) *dependent* who, on the date he or she is otherwise eligible for coverage, is adopted by, or placed for adoption with, the *subscriber;* or
    (2) a newly born *dependent* Child of the *subscriber,*

    if the child, as of the last day of the 30 day period beginning with the date or birth or date of adoption or placement for adoption, is covered under creditable coverage.

Other Limitations

Cost Effectiveness:
ADVANTAGE will not pay the cost of any *inpatient* or other care which could have been provided by a *participating physician's* office, in the *outpatient* department of a *hospital*, or in another less costly location without adversely affecting the patient's condition or the quality of medical care rendered, unless the UM Committee has determined the care to be *medically necessary*. Nor will *ADVANTAGE* pay the cost of any service or article which is significantly more expensive than an available alternative, unless the UM Committee has determined the more expensive service or article has been demonstrated to be of significantly greater therapeutic value than the other, less expensive, alternative.
Circumstances Beyond *ADVANTAGE's* Control:
Neither, *ADVANTAGE*, nor *participating hospitals*, nor any *participating provider* shall have any liability or obligation for delay or failure to provide health care services:

- Due to causes beyond the control of *ADVANTAGE* or *ADVANTAGE*'s *participating providers.* Such causes might include: complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of the *hospital personnel or health professionals*, or similar causes, under which the rendition of medical or *hospital* services hereunder is delayed or rendered impractical.

- Due to lack of available facilities or personnel if caused by disaster or epidemic.

In such events, *physicians and hospitals* shall render medical and *hospital* services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel as are then available.

SECTION 6: COMPLAINTS, *GRIEVANCE*S AND APPEALS

*GRIEVANCE*S – LEVEL 1

Members are encouraged to contact the Appeals Specialist at *ADVANTAGE* with any questions or *grievance*s. *You* may request a *grievance* within 180 *calendar* days from the date of the initial adverse decision. Please address *your* request for a *grievance* to the Appeals Specialist at the address or telephone number listed on page 2 of this *Certificate*, or *you* may call us, toll-free, at (888) 806-1029 between the hours of 8 am through 5 pm, Monday through Friday, excluding holidays. *You* may also call the number on the back of *your* identification card for assistance in filing a *grievance*. Please include the following information in *your* correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Social Security Number
The Nature of the *Grievance*

When the *grievance* is received, it will be recorded in the *Grievance* Log so that it can be tracked and resolved. A confidential file will be opened and maintained throughout the case until resolution, documenting the substance of the *grievance* and actions taken. *You* have the right to submit written comments, documents, or other information relating to the *grievance*.

You shall receive an acknowledgment of *your grievance* within three working days after receipt of *your grievance*.

*Grievance*s will be resolved according to the following time frames:

- Pre-service *grievance*s: A pre-service *grievance* or appeal is a request to change an adverse determination for care or services in advance of the *member* obtaining the care or services. *ADVANTAGE* resolves pre-service *grievance*s within 15 *calendar* days from receipt of the request at each level of review (first and second levels).

- Post-service *grievance*s: A post-service *grievance* or appeal is a request to change an adverse determination for care or services that have already been received by the *member*. *ADVANTAGE* resolves post-service *grievance*s within 20 business days after the *grievance* is filed. If we are unable to make a decision regarding the *grievance* within the twenty (20) day period due to circumstances beyond our control, then we shall: (1) notify *you* in writing advising of the reason for the delay before the twentieth business day, and (2) issue a written decision within an additional ten business days.

APPEALS LEVEL 2

If the *grievance* was not resolved to *your* satisfaction, *you* may appeal within 180 *calendar* days from the *grievance* decision by writing to the Appeals Specialist. Please address *your* request for an appeal to the Appeals Specialist at the address or telephone number listed on page 2 of this *Certificate*, or *you* may call us, toll-free, at (888) 806-1029 between the hours of 8 am through 5 pm, Monday through Friday, excluding holidays. *You* may also call the number on the back of *your* identification card for assistance in filing an appeal. Please include the following information in *your* correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Social Security Number
The Date of the Original *Grievance*
The Nature of the *Grievance*

You shall receive an acknowledgment of *your* request for a review by the second level Appeals Committee within three working days.

The appeal will be reviewed by the second-level Appeals Committee which, in the case of a *grievance* regarding medical care or treatment, will be composed of one or more individuals who have knowledge of the medical condition, procedure, or treatment at issue. The individual(s) will be in the same licensed profession as the *provider* who proposed, refused, or delivered the health care procedure, treatment, or service in question and who was not involved in the matter giving rise to the *grievance*.

If *you* wish to appear before the second-level Appeals Committee, *you* should make that request in the letter or telephone call requesting the appeal. *You* may also communicate with the Committee through other appropriate means if *you* are unable to appear in person. The Committee will meet during normal business hours. *You* may submit written comments, documents or other information relating to the appeal.

Appeals will be resolved according to the following time frames:

- Pre-service appeals: A pre-service *grievance* or appeal is a request to change an adverse determination for care or services in advance of the *member* obtaining the care or services. *ADVANTAGE* resolves pre-service appeals within 15 *calendar* days from receipt of the request at each level of review (first and second levels).

- Post-service appeals: A post-service *grievance* or appeal is a request to change an adverse determination for care or services that have already been received by the *member*. *ADVANTAGE* resolves post-service appeals within 30 *calendar* days from receipt of the request.

EXPEDITED *GRIEVANCE*S AND APPEALS

Expedited *grievance*s and appeals (Level I and Level II):

ADVANTAGE offers the *member* an expedited appeal for any *urgent care* request. *Urgent care* involves conditions which: "Could seriously jeopardize the life or health of the *member* or the ability of the *member* to regain maximum function, based on a prudent layperson's judgment or in the opinion of a *physician* with knowledge of the *member's* medical condition would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request."

ADVANTAGE must make the expedited *grievance* or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the request at each level of review (Level I and Level II). An expedited review begins when a *member*, a representative of the *member*, or a practitioner acting on behalf of the *member* requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication. *ADVANTAGE* grants an expedited review to all requests concerning admissions, continued stay or other health care services for a *member* who has received *emergency services* but has not been discharged from the facility.

ADDITIONAL INFORMATION

Right to Receive Information

For any level of appeal, *you* are entitled to receive, upon request, reasonable access and copies of all documents relevant to the *grievance* or appeal. Relevant documents include documents or records relied upon in making the decision and documents and records submitted in the course of making the decision. *You* are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or similar criterion on which the decision was based.

Designating a Representative

A *member* may designate a representative to file a *grievance* for the *member* and to represent the *member* in the resolution and/or appeal of any *grievance* or appeal. *You* may need to sign a release in order to allow us to discuss *your* situation with *your* representative.

External Review

If *you* are dissatisfied with our decision of the second-level review, *you* may have the option of requesting an external review by an Independent Review Organization certified by the Indiana Department of Insurance. If *you* choose to request an external review of *your* appeal, send a notice in writing within 180 *calendar* days of receipt of the second-level decision. Per Indiana Code IC 27-13-10.1-1, *you* may request an external review for the resolution of *grievance*s regarding:

1. an adverse utilization determination
2. an adverse determination of medical necessity: or
3. a determination that a proposed service is *experimental* or *investigational* made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating *physician*.

Please address *your* request for an external review to the Appeals Specialist at the address listed on page 2 of this *Certificate*:

Under the external review process, the Independent Review Organization will make a determination within 15 working days of *your* request, or for expedited requests, within 72 hours of receipt of *your* request. *You* may provide any requested information to the Independent Review Organization or authorize our release of information to the Independent Review Organization

You may be required to pay up to $25.00 of the costs for the external review. *You* may not file more than one external review request for each *grievance*. If *you* have the right to external review under Medicare, *you* may not request external review through the plan.

QUESTIONS AND CONCERNS

Your satisfaction is very important to us. We have set up the *Grievance* Procedure to help ensure that any problem with any aspect of this Plan is addressed in a fair and timely manner. We fully expect to provide a fair settlement for every valid *grievance* in a timely fashion. However, if *you* feel *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: (800) 622-4461 or
Indianapolis area: (317) 232-2395

Complaints can also be filed electronically at www.in.gov/idoi

You may also have remedies available to *you* through The Department of Labor and ERISA regulations.

SECTION 7: PAYMENT TO *PROVIDERS* AND CLAIMS FILING INFORMATION

Do I need to submit a claim for my in-network medical care?
No, *you* do not need to submit a claim. When *you* receive medical care from an in-*network participating provider*, including a *participating hospital*, that *participating provider* will submit all claims for *you*.

You must pay any *copayment* at the time of service. A *participating provider* may seek payment from *you* only for *deductible*s, *copayments*, *coinsurances* and for charges for *non-covered services*. Most of the time, *you* will not need to make a payment for *covered services*. After claims have been adjudicated, *your participating provider* will bill *you* for any services that are subject to *coinsurance*.

Do I need to submit a claim form for out-of-network care?
When services are provided by a *non-participating provider* or in the case of *emergency* medical services, *you* may need to pay the *provider* and then submit a claim. A *non-participating provider* may require *you* to pay any charges that are above the *Maximum allowable amount*. Please contact Member Services at the number shown on the Important Numbers page of this *Certificate*. They will provide instructions and a mailing address.

When will my claim be paid?
Claims will be paid within 45-days when filed on paper and 30 days when filed electronically after *ADVANTAGE* receives all information required to determine liability under the terms of this *Certificate*. If *ADVANTAGE* denies all or part *your* claim, *ADVANTAGE* (or *ADVANTAGE*'s designated agent) will provide *you* with a written notice that includes the reason(s) for denial.

When do I need to submit my claim?
A claim for a *participating provider* must be submitted within 90-days after the date the services are received or the date *you* made payment.

However, failure to give notice within the 90-day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within the period and that notice was given as soon as was reasonably possible.

Claims for *covered services* rendered by *providers* not *participating* with *ADVANTAGE* should be sent to the mailing address indicated in the "Network Administrator" section of *your ID card*. If a charge is made to *you* for any service that is reimbursable under the *Certificate*, written proof of such charge must be submitted to *ADVANTAGE* within 45-days after delivery of the service and must include an itemized statement plus diagnosis. Failure to furnish this documentation within the specific period will invalidate or reduce the claim unless, for a good reason, it was not possible to submit the claim within the specific period, and proof is produced on a timely basis as soon as possible thereafter.

ADVANTAGE will ordinarily make payment for *covered services* directly to the person or institution providing the services. However, if *you* furnish evidence that payment has been made by the *subscriber* to such person or institution for *covered services*, reimbursement will be made to the *subscriber* after deducting any payment made by *ADVANTAGE* before receipt of such evidence.

ADVANTAGE, at *ADVANTAGE's* own expense, shall have the right and opportunity to examine the *member* whose sickness or *injury* is the basis of a claim as often as it may reasonably require during the claim period.

Claims disputed by *you* will be resolved by the procedures set forth in this *Certificate*.

What do I do if I receive a bill for in-network medical care?
If *you* should receive a bill for in-network medical services for which *you* are not responsible, please call Member Services at the number shown on the Important Numbers page of this *Certificate*.

SECTION 8: *COORDINATION OF BENEFITS* WITH OTHER *COVERAGE*

This *coordination of benefits* (*COB*) provision applies when a person has health care *coverage* under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determines which *plan* will pay as the primary plan. The primary *plan* that pays first pays without regard to the possibility that another *plan* may cover some expenses. A secondary *plan* pays after the primary *plan* and may reduce the benefits it pays so that payments from all *Group plans* do not exceed 100% of the total allowable expense.

Definitions

- A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated *coverage* for members for a *Group*, the separate contracts are considered parts of the same *plan* and there is no *COB* among those separate contracts.
  (1) "Plan" includes: *Group* insurance, closed panel or other forms of *Group* or *Group*-type *coverage* (whether insured or uninsured); *hospital* indemnity benefits in excess of $100 per day; medical care components of *Group* long-term care contracts, such as skilled nursing care; medical benefits under *Group* or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  (2) "Plan" does not include: individual or family insurance; closed panel or other individual *coverage* (except for *Group*-type *coverage*); amounts of *hospital* indemnity insurance of $100 or less per day; school accident type *coverage*, benefits for non-medical components of *Group* long-term care policies; Medicare supplement policies, Medicaid policies and *coverage* under other governmental *plan*s, unless permitted by law.

  Each contract for *coverage* under (1) or (2) is a separate *plan*. If a *plan* has two parts and *COB* rules apply only to one of the two, each of the parts is treated as a separate *plan*.

- The order of benefit determination rules determine whether this *plan* is "primary plan" or "secondary plan" when compared to another *plan* covering the person.

  When this *plan* is primary, its benefits are determined before those of any other *plan* and without considering any other *plan*'s benefits. When this *plan* is secondary, its benefits are determined after those of another *plan* and may be reduced because of the primary *plan*'s benefits.

- "Allowable expense" means a health care service or expense, including *deductible*s and *copayment*s that are covered at least in part by any of the *plan*s covering the person. When a *plan* provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plan*s is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expense*s:
  (1) If a covered person is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plan*s routinely provides *coverage* for *hospital* private rooms) is not an *allowable expense*.
  (2) If a person is covered by 2 or more *plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expense*.
  (3) If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the primary *plan*'s payment arrangements shall be the *allowable expense* for all *plan*s.
  (4) The amount a benefit is reduced by the primary *plan* because a covered person does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred *provider* arrangements.

- "Claim determination period" means a *calendar year*. However, it does not include any part of a year during which a person has no *coverage* under this *plan*, or before the date this *COB* provision or a similar provision takes effect.

- "Closed panel *plan*" is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of *provider*s that have contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other *provider*s, except in cases of emergency or referral by a panel member.

- "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the *calendar year* without regard to any temporary visitation

Order of Determination Benefits Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary *plan* pays or provides its benefits as if the secondary *plan* or *plan*s did not exist.
- A *plan* that does not contain a *coordination of benefits* provision that is consistent with this regulation is always primary. There is one exception: *coverage* that is obtained by virtue of membership in a *Group* that is designed to supplement a part of a basic package of benefits may provide that the supplementary *coverage* shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical *coverage*s that are superimposed over base *plan hospital* and surgical benefits, and insurance type *coverage*'s that are written in connection with a *closed panel plan* to provide out-of-network benefits.
- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is secondary to that other *plan*.
- The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.
  1. Non-Dependent or Dependent. The *plan* that covers the person other than as a dependent, for example as an employee, *member*, *subscriber* or retiree is primary and the *plan* that covers the person as a dependent is secondary. However, if the

person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *plan* covering the person as a dependent; and primary to the *plan* covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two *plan*s is reversed so that the *plan* covering the person as an employee, *member*, *subscriber* or retiree is secondary and the other *plan* is primary.

2. Child Covered Under More Than One *Plan*. The order of benefits when a child is covered by more than one *plan* is:
   a. The primary *plan* is the *plan* of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care *coverage*.

      If both parents have the same birthday, the *plan* that covered either of the parents longer is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care *coverage* and the *plan* of that parent has actual knowledge of those terms, that *plan* is primary. This rule applies to *claim determination period*s or *plan* years commencing after the *plan* is given notice of the court decree.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The *plan* of the *custodial parent*;
      - The *plan* of the *spouse* of the *custodial parent*;
      - The *plan* of the non-*custodial parent*; and then
      - The *plan* of the *spouse* of the non-*custodial parent*.
3. Active or Inactive Employee. The *plan* that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other *plan* does not have this rule, and if, as a result, the *plan*s do not agree on the order of benefits, this rule is ignored. *Coverage* provided an individual as a retired worker and as a dependent of an actively working *spouse* will be determined under the rule labeled B (1).
4. Continuation *Coverage*. If a person whose *coverage* is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an employee, *member*, *subscriber* or retiree (or as that person's dependent) is primary, and the continuation *coverage* is secondary. If the other *plan* does not have this rule, and if, as a result, the *plan*s do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of *coverage*. The *plan* that covered the person as an employee, *member*, *subscriber* or retiree longer is primary.
6. If the preceding rules do not determine the primary *plan*, the *allowable expense*s shall be shared equally between the *plan*s meeting the definition of *plan* under this regulation. In addition, this *plan* will not pay more than it would have paid had it been primary.

Effect on the Benefit of this *Plan*

- When this *plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *plan*s during a *claim determination period* are not more than 100 percent of total *allowable expense*s. The difference between the benefit payments that this *plan* would have paid had it been the primary *plan* and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this *plan* to pay any *allowable expense*s, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will:
  1. Determine its obligation to pay or provide benefits under its *contract*;
  2. Determine whether a benefit reserve has been recorded for the covered person; and
  3. Determine whether there are any unpaid *allowable expense*s during that claims determination period.

  If there is a benefit reserve, the secondary *plan* will use the covered person's benefit reserve to pay up to 100% of total *allowable expense*s incurred during the *claim determination period*. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

- If a covered person is enrolled in two or more *closed panel plan*s and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*; *COB* shall not apply between that *plan* and other *closed panel plan*s.

Right to Receive and Release Needed Information

Certain facts about health care *coverage* and services are needed to apply these *COB* rules and to determine benefits payable under this *plan* and other *plan*s. *ADVANTAGE* may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plan*s covering the person claiming benefits. *ADVANTAGE* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give *ADVANTAGE* any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *ADVANTAGE* may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under

this *plan*. *ADVANTAGE* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by *ADVANTAGE* is more than it should have paid under this *COB* provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 9: SUBROGATION/RIGHT OF REIMBURSEMENT

Subrogation means: If *your injury* or *illness* is caused by the acts or omissions of another party (including insurance *carriers* who are so liable), and *ADVANTAGE* has provided benefits under this *Certificate*, *ADVANTAGE* will have the right to be reimbursed if *you* receive any payment from the other party.

- *ADVANTAGE* is subrogated to all of *your* rights against any party legally liable to pay for *your injury* or *illness*.
- *ADVANTAGE* may assert this right independently of *you*.
- *You*, or anyone acting legally on *your* behalf must:
  - fully cooperate with *ADVANTAGE* in order to protect *ADVANTAGE*'s subrogation rights;
  - give notice of *ADVANTAGE*'s claim to third parties and their insurers who may be legally responsible;
  - provide *ADVANTAGE* with relevant information and sign and deliver such documents as *ADVANTAGE* reasonably request to secure *ADVANTAGE*'s subrogation claim; and
  - obtain *ADVANTAGE*'s consent before releasing any party from liability for medical expenses or services paid or provided.

If *you* enter into litigation or settlement negotiations regarding the obligations of other parties, *you* must not prejudice, in any way, *ADVANTAGE*'s subrogation rights.

SECTION 10: TERMINATION OF *COVERAGE*

The *coverage* provided in this *Certificate* for *you* and *your eligible dependents* and *young adults*, if any, may be terminated by *ADVANTAGE* upon the occurrence of any of the following events:

- You revoke your consent for ADVANTAGE to utilize your personal medical information for future, known, or routine needs for the purpose of treatment, payment, and health care operations.
- The termination of the *Contract* between *your Group* and *ADVANTAGE*.
- The *Group* fails to pay *ADVANTAGE premium* due on *your* behalf.
- *You* no longer qualify for eligibility based on the requirement of working or residing within the defined *ADVANTAGE service area.*
- Upon thirty-one (31) days prior written notice by *ADVANTAGE* if:
  - *You* fail to pay *copayments* or *coinsurance* required for *covered services*, or *premium* contributions, if any; or
  - *You* are unable to establish and maintain a satisfactory *hospital* or patient-*health professional* relationship with *participating hospitals* and *health professionals*; or
  - *You* commit fraud against *ADVANTAGE* or a *participating provider* by, for example:
    Allowing a non-*member* to use *your ADVANTAGE ID card* to obtain services;
    - Making any false statement or representation on *your* membership application;
    - Falsifying a prescription, stealing or otherwise misappropriating a prescription blank(s) or other property of a *participating provider* of *ADVANTAGE*;
    - Altering *your* medical record; or
    - Obtaining similar drug therapy or prescriptions from two or more *providers*, without *proper referral* or without informing the *providers* of *your* complete prescription profile, when done for the purpose of providing such prescriptions to someone other than the person for whom the medication was intended or for the purpose of self-administration of multiple prescriptions without the knowledge or approval of *your PCP*.
- *You* behave in a violent or abusive manner toward the staff of an *ADVANTAGE participating physician*, a *provider network*, or *ADVANTAGE*;
- *You* otherwise repeatedly violate the terms of this *Certificate* or *ADVANTAGE* rules; or
- *You* fail to cooperate with *ADVANTAGE* in the administration of the *coordination of benefits* provisions set forth in this *Certificate*.
- For other good cause as may from time to time be permitted by law. If membership is terminated for any of the grounds specified in this section, all rights to service cease as of the date of termination and there is no right to convert to an individual *carrier*.
- *Your spouse* will cease to be eligible for *coverage* hereunder on the first of the month following the month in which a final decree of dissolution of the marriage is recorded, unless *coverage* is continued in accordance with the terms of this *Certificate* or unless terminated sooner pursuant to the terms of this *Certificate.*

- If *you* are eligible to be covered under Medicare, *you* must enroll in Part A and Part B Medicare *coverage* on the date eligible in order to continue *coverage* under this *Certificate*. An exception to this rule applies to an actively employed *member* or the *spouse* of an actively employed *member* when *ADVANTAGE* is the primary payor. "Deemed Entitlement to Medicare" means any Covered Person who is an eligible retiree or the *spouse* of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B *Coverage* for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medicate *Coverage*. In cases where Medicare is primary, the Plan estimates Medicare's primary share and pays only the secondary charges.
- *Your* child's *coverage* will terminate once he/she has reached the attainment of the limiting age, unless *coverage* is extended as described in the "Eligibility, Enrollment, *Coverage*" Section of this *Certificate* or is terminated sooner due to the terms of this *Certificate* . If you wish to obtain coverage under the Young Adult Coverage Rider you must notify your employer within 31 days of the dependent reaching the limiting age otherwise coverage will terminate.
- Termination of *coverage* for *you* and any enrolled family members, including a *young adult* due to termination of employment shall be determined by the *Group*; not withstanding any continuation of *coverage* addressed elsewhere in this *Certificate* .

If *you* believe that *coverage* has been canceled or not renewed because of *your* health status, need for health care services or exercise of *your* rights under the *grievance* procedure, *you* may request review by *ADVANTAGE* or by the Department of Insurance. Please refer to the "*Grievance*s and Appeals" Section of this *Certificate.*

In the event of the termination of the *Contract* between *Group* and *ADVANTAGE* or enrollment termination of any individual *member*, *coverage* for any prescription medication provided for under this *Certificate* will only be provided for the specific quantity of prescription medication that will actually be used or consumed by the *member* through the last day of eligibility, regardless of the pharmacy source for the medication. *Member* will be financially responsible for all quantities of prescription medication that will be used or consumed after the last day of eligibility, even if that medication is dispensed as part of a prescription partially covered by this *Certificate* prior to the termination.

Voluntary termination

- If *you* choose *coverage* under any other Plan that is offered by, through, or in connection with *your Group*, in lieu of *coverage* with *ADVANTAGE*, *coverage* for *you* and *your eligible dependents* will terminate on the date and time that the other *coverage* becomes effective. *Your Group* agrees to notify *ADVANTAGE* immediately when *you* elect other *coverage*.
- *You* may terminate *your coverage* and *your eligible dependent'(s')* or *young adult'(s') coverage*, if there is a qualified change in family status or during open enrollment, by giving written notice to *your Group*. The termination shall be effective on the last day of the month upon receipt of such notice by *ADVANTAGE* unless otherwise specified.

Your coverage (and *dependents* or *young adults* if applicable) shall terminate on the date determined by *your Group*.

Certificates of *Creditable Coverage*

If *your coverage* with *ADVANTAGE* terminates, *you* may be asked by the replacement *carrier* for a Certificate of *Creditable Coverage*. "*Creditable Coverage*," with respect to an individual, is *coverage* of the individual under any of the following types of insurance plans:

- a *Group* health plan or individual health plan;
- Part A or B of Medicare;
- Medicaid;
- CHAMPUS;
- a medical care program of the Indian Health Service or tribal organizations;
- a state health benefits risk pool, such as Children's Health Insurance Program;
- the federal employees health benefits program;
- a public health plan; (a plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance *coverage* to individuals);
- a health benefit plan under the Peace Corps Act; or
- a church plan.

In the event that *you* disenroll from *ADVANTAGE*, the Certificate of *Creditable Coverage* will help *your* new insurance *carrier* determine to what extent its *preexisting medical condition* exclusions apply, if any. If *you* were not without *coverage* for more than 63 days, the new insurance company must reduce its *preexisting medical condition* exclusions under *your* new insurance policy. *ADVANTAGE* will provide *you* with a Certificate of *Creditable Coverage* upon *your* disenrollment that will show the *effective date* of *your coverage* with *ADVANTAGE*. *ADVANTAGE* will make these Certificates available when:

- *You* are no longer eligible with *ADVANTAGE*;
- *You* reach the end of Consolidated Omnibus Budget Reconciliation (COBRA) *coverage*; and/or
- Upon *your* request, but only if the request is made within 24 months after *coverage* ends. *ADVANTAGE* will also provide to *your* new insurance *carrier*, upon request, a *Certificate* explaining *your* benefits under *ADVANTAGE*

SECTION 11: CONTINUATION OF *COVERAGE*

Do I have the option of continuing my *coverage* after termination?

- **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986**

  If *you* are covered under a *Group* which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the following shall apply:

  In order to obtain COBRA to continue *coverage* under this *Certificate*, *your Group* must:
  - notify *you* of *your* right to continued *Group coverage*, as required by federal law;
  - notify *ADVANTAGE* as soon as possible when *you* elect COBRA, including the date *your* COBRA *coverage* becomes effective;
  - collect and forward all applicable *premiums* to *ADVANTAGE* on a timely basis.

  If *you* have any questions about COBRA, *you* should speak with *your Group* directly.

- **Continuation of *Coverage* under Disability**

  You may become totally disabled while covered under this *Certificate* and still be totally disabled at the time this *Certificate* terminates or non-renews. If so, and if *you* pay the *premiums* that apply, *you* will be allowed to extend *your* benefits, under this *Certificate*, for the condition causing such disability, until the sooner of:
  - The date *you* become covered under, or eligible to be covered under, another *carrier* or policy affording similar benefits;
  - A period of three (3) months from the date *coverage* hereunder would have otherwise ended had *you* not been so disabled; or
  - The date *you* cease to be totally disabled.

  Benefits will not be said to be "similar" if *you* would be subject to a *pre-existing medical condition* or waiting period covering the disabling condition under the replacement policy. For the purposes of this *Certificate* , "total disability" means a disease or bodily *injury* (excluding normal pregnancy) which, in fact prevents or may reasonably be expected to prevent *you* from engaging, for a period of at least one (1) year, in any work for which *you* are or become qualified by reason of education, training or experience; or which prevents or may be expected to prevent *you* from performing, for a period of at least one (1) year, the important activities normal for a person of that age and family status. The fact that *you* are in the *hospital* at the time the *Certificate* ends is not by itself proof of "total disability". Nothing in this Section shall be deemed to prevent *ADVANTAGE* from coordinating benefits with the prior *carrier* or with another *Group carrier* with whom a totally disabled *member* may have health care *coverage*.

- **Individual Conversion**

  You may be eligible to obtain Individual Conversion *coverage* after *your* benefits with *your Group*, *ADVANTAGE* and/or COBRA expire. The *Individual Conversion Contract* is provided through *ADVANTAGE* Health Solutions, Inc. To obtain more information, contact ADVANTAGE Health Solutions at 9045 River Road, Ste 200 Indianapolis IN 46240, 1-800-553-8933.

  You may be entitled to an *Individual Conversion Contract*, without evidence of insurability, if:

  - *You* meet the eligibility requirements for an *Individual Conversion Contract* pursuant to Indiana Code 27-8-15-31;
  - *You* were continuously covered under this *Certificate* for at least 90-days;
  - *You* request the conversion policy from *ADVANTAGE* within 30 days of loss of *coverage*; and
  - *You* cease to be covered under this *Certificate* as a result of:
    - leaving *your Group* or a reduction in *your* hours of employment;
    - the *subscriber's* death or termination of marriage; or
    - ceasing to meet the definition of *eligible dependent.*

  If eligible for COBRA *coverage*, *you* must exhaust COBRA *coverage* before requesting a conversion policy. The conversion policy will be issued without regard to health status or requirements for health care services. If *you* elect to exercise this conversion privilege, the conversion shall be effective retroactive to the date and time *coverage* terminated under this *Certificate*, subject to the payment of any applicable *premium* due.

  You must pay *ADVANTAGE*, less any *copayment* and *coinsurance*, for the reasonable value of health services or benefits provided under this *Certificate* during the 30-day election period, if the conversion privilege is not exercised.

- **Extension of *Coverage* If *You* Are Confined to the *Hospital***

  If *you* are *hospital*ized for a medical or surgical condition on the date of termination of this *Certificate*, *you* will have continuation of *coverage* for *inpatient* services until the sooner of:
  - *Your* discharge from the *hospital*;
  - Sixty (60) days pass after the termination date of this *Certificate* ;
  - *You* obtain *coverage* from another *carrier* which includes *coverage* for *inpatient* services provided by this *Certificate* ;
  - Termination of *your Group's Group Service Agreement* by *ADVANTAGE*, as determined by:

- The *effective date* specified in written communication sent to *ADVANTAGE* by *your Group*, or
- Failure to pay a *premium* within the grace period permitted under the *Group Service Agreement*.

- Termination of *your coverage* and this *Certificate* by *ADVANTAGE* due to:
  - *You* knowingly providing false information to *ADVANTAGE*;
  - *Your* failure to comply with the rules stated in this *Certificate* ; or
  - *You* fail to pay *premium* within the grace period permitted in *your Group's Group Service Agreement*.

- **Exceptions to Continuation of *Coverage* and Conversion**

  Neither *you* nor *your eligible dependents* will be eligible for continuation of *coverage* under COBRA or for conversion to an *Individual Conversion Contract* if any of the following circumstances apply:

  - *You* do not meet the eligibility guidelines for an *Individual Conversion Contract* set forth in Indiana Code 27-8-15-31;
  - *Coverage* was terminated by *ADVANTAGE* or *your Group*; or
  - *You* have moved out of the geographic area in which *ADVANTAGE* is licensed to operate (Applies to individual conversion only).

In the event that *you* are deemed ineligible for conversion, *your eligible dependents* will also be deemed ineligible for conversion, unless otherwise required by law.

SECTION 12: OTHER IMPORTANT INFORMATION

Care Management

ADVANTAGE is committed to providing *members* with highest quality of care in the most cost-effective manner. In order to meet this endeavor, *ADVANTAGE* manages care using the following:

- Proper Referral Process **–**If services are not available within the *participating provider network*, *ADVANTAGE* will work with the *member* and *referring physician* to refer the *member* to the appropriate *provider* of service based on their condition.

- *Pre-Certification* **–** Pre-approval or certification of certain services (i.e. Physical Therapy, *Hospital*izations, etc.). *Your referring physician* is responsible for obtaining any *pre-certifications* unless *you* are a Point of Service *member*, where this is *your* responsibility.

- Concurrent Review **–** A review conducted of all *inpatient* admissions to assess whether there is a need for a continued stay. This process ensures that *members* only stay as long as *medically necessary* and at the same time are not discharged prior to necessity.

- Discharge Planning **–** This process is in place to ensure appropriate and timely discharge from the *hospital* to a more appropriate level and setting of care such as home health care.

- Case Management **–** This program is designed to be used in cases of *members* who are in need of long term care. A nurse is assigned to the *member* to work with the *member's physicians* and the *member* about a treatment plan. The patient, *provider* and Case Manager must all agree on the most cost effective treatment method, while assuring quality medical care.

- Preventive Health **–** Each of *ADVANTAGE's* benefit plans offer preventative health benefits designed to promote wellness and early detection of potential health problems.

- Disease Management **–***ADVANTAGE* empowers *members* who have conditions like Asthma, Hypertension, Cardiac Heart Failure, Depression, and Diabetes by providing them information on their condition to assist them with their conditions. *ADVANTAGE* provides them with newsletters and other materials on their conditions. Also, a member can choose to enroll and actively participate in *ADVANTAGE*'s Disease Management to receive discounted copays for certain disease-specific medications.

Provider Termination

- Occasionally, a *physician* may no longer participate with *ADVANTAGE* due to retirement, death, relocation, termination, etc. If *your PCP* or *SCP* ceases to be an *ADVANTAGE participating provider*, *ADVANTAGE*'s Member Services Department will make good faith efforts to notify *you* within 30 days prior to the *effective date* of termination. *You* will receive instructions on how to select a new *physician*.

- If *you* are currently in active treatment with the terminating *physician*, or *you* are in *your* third trimester of pregnancy, please contact an *ADVANTAGE* Member Services Representative. *You* may be able to continue *your* care with the *physician* until the completion of *your* treatment or up to 90-days, whichever is shorter. A representative will assist *you* or direct *you* to *ADVANTAGE*'s Care Coordinator. *ADVANTAGE*'s goal is to ensure *you* have access to continuity of care until *your* current treatment plan has ended, or until *your* pregnancy has been delivered.

- If *you* need an updated *Provider Directory* or other assistance in selecting a *physician*, *ADVANTAGE*'s Member Services Department will help *you*.

- Upon termination of a contract with a *participating provider*, *ADVANTAGE* shall be liable for payment of *covered services* rendered by the *provider* to *you* under the care of the *provider* at the time of termination until services being rendered to *you* by the *provider* are completed, unless *ADVANTAGE* makes reasonable and medically appropriate provision for assumption for services by another *provider*.

Notice of Material *Provider* Change
ADVANTAGE will provide written notice to *you*, within a reasonable time, after learning of an action by a *participating provider* that has a material effect on the *Group* or *you*. Examples of such actions may include: leaving *ADVANTAGE*'s *participating provider network*; material breach of contract; or being unable to perform key contract terms, but only if any of those actions affects *you* in a material way.

Utilization Management (UM) Decision Maker
- UM decision making is based only on appropriateness of care and service and existence of *coverage*.
- *ADVANTAGE* does not specifically reward *provider*s or other individuals for issuing denials of *coverage* or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Medical Technology Assessment
- *ADVANTAGE* provides a process to evaluate new medical technologies, services and pharmacological treatment to assure appropriate access to such services by the *member* population. *ADVANTAGE* develops protocols for new technology proactively and reactively. As *ADVANTAGE* becomes aware of new technology, the new technology guidelines outlined in this process are followed to prepare *ADVANTAGE*'s position regarding the new technology in anticipation of a future request.
- The *member's physician* must request an approval, prior to the service date and in writing, regarding the recommended treatment or service that is a new medical technology, *experimental* or investigative treatments and services.
- *ADVANTAGE* has available participating specialists, sub-specialists, pharmacists, and a referral center (Hayes, Inc.) to assist with the review and determination regarding new medical technology.
- *ADVANTAGE* contracts with Hayes, Inc. to provide a database and access to research regarding various medical technologies, including new use of existing technologies and newly developed technologies. Elements of the Hayes technology assessment process include:
  - Application of rigorous methods of scientific inquiry which encompass a thorough search of the peer-reviewed scientific literature
  - Critical appraisal of the data reported with respect to study design and clinical significance of outcomes
  - Comparative analysis of alternatives

  There are many healthcare technologies assessed by Hayes, Inc. and accessible to *ADVANTAGE* including:
  - Medical and surgical procedures, including transplants
  - Drugs and pharmaceuticals
  - Diagnostic and screening tests
  - Alternative therapies
  - Behavioral Health procedures
  - Medical devices/equipment
- Requests for approval of new medical technology procedures/services that involve a *member* whose health situation is life threatening will be resolved and the *physician*/*member* notified within 72 hours of the request.
- Technology assessments for non-urgent situations should be submitted 5-7 days prior to the service date if possible to allow adequate time to investigate the proposed treatment or service. A response to a written request for non-urgent technology assessment is provided within 15 *calendar* days of receiving the request. Medical Management notifies the *PCP*, *SCP*, and facility by telephone of the recommendation to approve or deny *coverage* within one business day. Notification letters are mailed to the *PCP*, *SCP*, and *member* within two (2) business days of the determination to approve or deny new medical technology.
- If the Medical Director denies a request for a new technology service/procedure, a denial notification letter is sent to the *member*, *PCP*, and *SCP* outlining the principle reason for the denial, criteria utilized, and the appeals process.

Severability
In the event that any provision of this *Certificate* is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this *Certificate*, which shall continue in full force and effect in accordance with its remaining terms.

Worker's Compensation
This *Certificate* is not in lieu of and does not affect any requirement or *coverage* by Worker's Compensation Insurance.

Rights to *Covered services* Not Transferable
No person other than *you* or *your eligible dependent* is entitled to receive health care services or other benefits to be furnished by *ADVANTAGE* under this *Certificate*. The right to health care services or other benefits is not transferable.

Right to Change Control when required by Law
ADVANTAGE will apply this *Certificate* in agreement with state and federal laws and regulations. If any part of this *Certificate* does not agree with state or federal laws or regulations, this *Certificate* is deemed amended and *ADVANTAGE* will change *ADVANTAGE*'s procedures to conform to the laws and regulations. *ADVANTAGE* reserves the right to terminate the C*ontract* and re-rate the C*ontract* based on the changes at the time of renewal of this *Certificate*.

Assignment of Benefits Payments
You are not permitted to assign benefits or payments for services covered under this *Certificate*.

Relationship Among Parties Affected by this *Certificate*

- The relationship between *ADVANTAGE* and participating *health professional*s and/or *provider networks* is that of independent contractors. *ADVANTAGE* is not a "professional" corporation and so does not practice medicine or direct the professional practice of medicine by any *health professional*. Neither participating *health professional*s nor *provider networks* are employees of *ADVANTAGE*, nor are they agents of *ADVANTAGE*. Nor is *ADVANTAGE* or any of *ADVANTAGE*'s employees an employee or agent of the *health professional*s or *provider networks* who participate in *ADVANTAGE*'s provider panel. *Health professional*s are responsible for maintaining professional-patient relationships with the *member*. *Health professional*s are solely responsible to the *member* for all medical services.

- *Participating providers* may receive a financial incentive from *ADVANTAGE* to appropriately manage the provision and cost of services rendered to *you*.

- Neither the *Group*, nor any *member*, is an agent or representative of *ADVANTAGE*. Neither the *Group*, nor any *member*, shall be liable for any acts or omissions of *ADVANTAGE*, *ADVANTAGE*'s agents or employees, or of any *participating health professional*, or *participating hospital*, or any other person or organization with which *ADVANTAGE*, *ADVANTAGE*'s agents or employee, has contracted for the performance of services under this *Certificate*.

- Certain *members* may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by an *ADVANTAGE participating health professional*. *Health professionals* shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the *member's* wishes, insofar as this can be done consistently with the *participating health professional's* judgment as to the requirements of proper medical practice. If a *member* refuses to follow a recommendation treatment or procedure, and a *participating health professional* believes that no professionally acceptable alternative exists, such *member* shall be so advised. The *member* will have the right to consultation (*second opinion*) from an appropriate *ADVANTAGE participating physician* regarding his or her medical condition. If both *participating physicians* agree as to the course of treatment, and the *member* still refuses to follow the recommendation, *ADVANTAGE* will cease to *provide covered services* or pay for treatment for such condition. At such time the *member* agrees to follow the recommended treatment or procedure, *covered services* will resume.

SECTION 13: NOTICE OF PRIVACY PRACTICES

ADVANTAGE is required by applicable federal and state laws to maintain the privacy of *your* health information. We are also required to give *you* this notice about our privacy practices, our legal duties, and *your* rights concerning *your* health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2005, and will remain in effect until we replace it.

ADVANTAGE reserves the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. *ADVANTAGE* reserves the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information *ADVANTAGE* created or received before we made the changes. Before we make significant change in our privacy practices, *ADVANTAGE* will change this notice and send the new notice to our health *subscribers* at the time of the change.

You may request a copy of our notice at any time. If *you* would like to request a copy or obtain additional information, please contact us using the contact information listed at the end of this notice.

Uses and Disclosures of Health Information
The sections below describe the ways *ADVANTAGE* uses and releases *your* health information. *Your* health information is not shared with anyone who does not have a "need to know" to perform one of the tasks listed below.

- **Treatment**: *ADVANTAGE* may use *your* health information or disclose it to third parties to coordinate and oversee *your* medical care. For example, we may use *your* health information to help *you* find a doctor or a *hospital* that can treat *your* specific health needs.

- **Payment**: *ADVANTAGE* may use *your* health information or disclose it to third parties to pay for *your* medical care. For example, we may use *your* health information when we receive a claim for payment. *Your* claims tell us what services *you* received and may include a diagnosis. *ADVANTAGE* may also disclose this information to another insurer if *you* are covered under more than one health plan.

NOTE: Non-English speaking *member*s can access Member Services, Utilization Management and Care Coordination, and other *ADVANTAGE* services for *member* treatment, payment or *ADVANTAGE* operations. *ADVANTAGE* contracts with Language Line Services to assist non-English speaking *member*s in accessing *ADVANTAGE* resources and getting answers to questions. The interpreters may communicate directly with the *member* and *ADVANTAGE* representatives to resolve *member* questions. The communication may include information related to *your* health care. As concepts familiar to English speakers often require explanation or elaboration in other languages and cultures, the interpreters will then convey the communications meaning-for-meaning not necessarily word-for-word.

- **Health Care Operations**: *ADVANTAGE* may use *your* health information and disclose it to third parties in order to assist in *ADVANTAGE*'s everyday work activities such as looking at the quality of *your* care, carrying out utilization review, and *ADVANTAGE*'s business planning. For example, *your* health information may be released to members of *ADVANTAGE* staff to review the quality of care and outcomes. *Your* health information may be released to doctors or doctor groups involved in *your* care to improve patient care. Additionally, *ADVANTAGE* publishes the Health Group Data Information Set (HEDIS) which is a report of *ADVANTAGE member*'s health care measurement data. *ADVANTAGE* also publishes the Commercial Adult Health Plan Survey (CAHPS) results, which measures *ADVANTAGE member* satisfaction. *ADVANTAGE*'s policy reflects that we utilize methodologies that protect the identity of individual *member*s, such as not connecting specific survey responses to individual *member*s, not providing any *member* specific data in the measurement data, etc.

  NOTE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to inform you of your right, our legal duties and our privacy practices. By enrolling in this Plan, *you* understand that *ADVANTAGE* has the right to utilize *your* personal medical information for future, known or routine needs for the purposes of treatment, payment, and health care operations. ***You* understand this consent is a condition of *your* enrollment in *ADVANTAGE* and *you* have the right to revoke this consent in writing at any time.**

- **To *You* and Upon *Your* Authorization**: *ADVANTAGE* must disclose *your* health information to *you*, as described in the Individual Rights section of this notice, below. *You* may give us written authorization to use *your* health 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. Without *your* authorization, we may not use or disclose *your* health information for any reason except those described in this notice

- **To *Spouse* or Parent:** Unless *you* specifically request that *ADVANTAGE* not disclose such information, *ADVANTAGE* may disclose *your* health information to *your spouse* or parent, in compliance with applicable privacy laws, to help with *your* health care or payment for health care services. *Your* request to not disclose health information to a *spouse* or parent must be in writing, signed by the individual authorized to make such a request, and sent to the Contact Information listed at the end of this notice.

- **To Plan Sponsor (*Group*):** *ADVANTAGE* may disclose limited summary health information about *you* to *your* plan sponsor (*Group*). "Summary Health Information" is information that summarizes the claims history, claims expenses or types of claims experienced by *you* and other members of *your Group* health plan, from which specific identifiers have been deleted. However, *ADVANTAGE* may disclose *your* identifiable health information and the identifiable health information of others enrolled in *your Group* health plan to *your* plan sponsor (*Group*) only:
  1. If *you* authorize us to disclose the information by completing an authorization form; or
  2. If necessary for the *Group* to perform plan administration functions on behalf of the *Group* health plan, and *ADVANTAGE* receives a certification from the plan sponsor (*Group)* that satisfies all of the requirements of HIPAA, which allow for the release of identifiable health information.

- **To Family and Friends**: If *you* agree, or if *you* are unavailable to agree, when the situation, such as medical *emergency* or disaster relief, indicates that disclosure would be in *your* best interest, *ADVANTAGE* may disclose *your* health information to a family member, friend or other person to the extent necessary to help with *your* health care services.

- **Underwriting**: *ADVANTAGE* may receive *your* health information for underwriting, *premium* rating or other activities relating to the creation, renewal or replacement of a C*ontract* of health insurance or health benefits. We will not use or further disclose this health information for any other purpose, except as required by law, unless the *Contract* of health insurance or health benefits is placed with us. In that case, our use and disclosure of *your* health information will only be as described in this notice.

- **Marketing**: *ADVANTAGE* may use *your* health information to contact *you* with information about health-related benefits and services, including but not limited to, *ADVANTAGE*'s disease management programs and *quality improvement* activities that may be of interest to *you*. We may disclose *your* health information to a business associate to assist us in these activities. Unless the information is provided to *you* by a general newsletter, in person, or is for products or services of nominal value, *you* may opt-out of receiving further such information by telling us using the contact information listed at the end of this notice.

- **Research; Death; Organ Donation**: *ADVANTAGE* may use or disclose *your* health information for research purposes in limited circumstances. We may disclose the health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety**: *ADVANTAGE* may disclose *your* health information to the extent necessary to avert a serious and imminent threat to *your* health or safety or the health or safety of others. We may disclose *your* health information to a government agency authorized to oversee the health care system or government programs or its contractors, and public health authorities for public health purposes. We may disclose *your* health information to appropriate authorities if we reasonably believe that *you* are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law**: *ADVANTAGE* may use or disclose *your* health information when we are required to do so by law. For example, we must disclose *your* health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy law. We may disclose *your* health information when authorized by workers' compensation or similar laws.
- **Process and Proceedings**: *ADVANTAGE* may disclose *your* health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose *your* health information to law enforcement officials.
- **Law Enforcement**: *ADVANTAGE* may disclose limited information to a law enforcement official concerning the health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the health information of any inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security**: *ADVANTAGE* may disclose to Military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses of Health Information – By Authorization Only
Other uses and disclosures of health information not covered by this Notice or the law that apply to us will be made only with *your* written authorization. If *you* provide us with an authorization to use or release health information about *you*, *you* may end that authorization, in writing, at any time. If *you* end *your* authorization, we will no longer use or release health information about *you* for the reasons covered by our written authorization. *You* understand that we are unable to take back any disclosures we have already made with *your* authorization.

A parent, legal guardian, or properly named patient advocate may represent *you* if *you* cannot provide an authorization. Authorization is needed for certain release of information dealing with mental health issues, substance abuse issues, HIV/AIDS and *grievance*s. We can provide *you* with a sample authorization form. *You* may also end an authorization by writing to *ADVANTAGE* at the contact information list at the end of this Notice.

Confidentiality in All Settings
ADVANTAGE has policies and procedures in place that protect the privacy of *your* information.
- Every employee signs a statement when they are hired that they understand they are required to keep *member* information private. They also learn about the actions the company will take if the privacy policies are not followed.
- *ADVANTAGE* has strict control of access to electronic, and paper information specific to *member*s. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for *member*s.

ADVANTAGE tells all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours. In addition, *ADVANTAGE* will not share any *member* information with a *Group* without specific authorization from the *member*.

ADVANTAGE's Compliance Committee reviews our confidentiality policies and procedures every year. These committees also reviews how we collect, use, dispose of, and disclose *your* information. *Members* (or prospective *members)* and *providers* have the right to review *ADVANTAGE*'s privacy policies and procedures. *You* may get copies by contacting Member Services.

Changes to this Notice
ADVANTAGE has the right to change the terms of this Notice. We have the right to make these changes, which apply to health information we already have about *you* as well as any we receive in the future. We will always post a copy of the current Notice on *ADVANTAGE*'s web site. *You* will also receive materially revised Notices within 60 days of their effective date.

Individual Rights
- **Access**: *You* have the right to inspect or obtain copies of *your* health information, with limited exceptions. *You* may request that *ADVANTAGE* provide copies in a format other than photocopies (i.e. electronic). We will use the format *you* request unless we cannot practicably do so.

- **Disclosure Accounting**: *You* have the right to receive a list of instances in which *ADVANTAGE* or our business associates disclosed *your* health information obtained or created since April 14, 2003 for purposes other than treatment, payment or health care operations and certain other authorizations. We will provide *you* with the date(s) on which we made the disclosure, the name(s) of the person or entity (ies) to whom we disclosed *your* health information, a description of the health information disclosed, and certain other information. If *you* request this list more than once in 12-month period, we may charge *you* a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

- **Restriction Request:** *You* have the right to request that *ADVANTAGE* place additional restrictions on our use or disclosure of *your* health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our *Agreement* (except in an *emergency*). Any *Agreement ADVANTAGE* may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an *Agreement* on *your* behalf. *ADVANTAGE* will not be bound unless our *Agreement* is so memorialized in writing.

- **Confidential Communication**: *You* have the right to request that *ADVANTAGE* communicate with *you* in confidence about *your* health information by alternative means or to an alternative location. *You* must inform us that confidential communication by alternative means or to an alternative location is required to avoid endangering *you*. *You* must make *your* request in writing, and *you* must state that the information could endanger *you* if it is not communicated in confidence by the alternative means or to the alternative location *you* want. *ADVANTAGE* must accommodate *your* request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect *premiums* and pay claims under *your* health plan.

- **Amendment**: *You* have the right to request that *ADVANTAGE* amend *your* health information. *Your* request must be in writing, and it must explain why the information should be amended. *ADVANTAGE* may deny *your* request if we did not create the information *you* want amended or for certain other reasons. If we deny *your* request, we will provide *you* a written explanation. *You* may respond with a statement of disagreement to be appended to the information *you* wanted amended. If we accept *your* request to amend the information, we will make reasonable efforts to inform others, including people *you* name, of the amendment and to include the changes in any future disclosures of that information.

- **Electronic Notice**: If *you* receive this notice on our web site (www.advantageplan.com) or by electronic e-mail, *you* are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If *you* are concerned that we may have:

- Violated *your* privacy rights;
- *You* disagree with a decision we made about access to *your* health information;
- In response to a request *you* made to amend or restrict the use or disclosure of *your* health information; and/or
- In response to a request *you* made to have us communicate with *you* in confidence by an alternative means or at an alternative location

You may complain to *ADVANTAGE* using the contact information listed at the end of this notice. *You* also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide *you* with the address to file *your* complaint with the U.S. Department of Health and Human Services upon request.

ADVANTAGE supports *your* right to protect the privacy of *your* health information. We will not retaliate in any way if *you* choose to file a complaint with us or the U.S. Department of Health and Human Services. If *you* want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

ADVANTAGE Health Solutions, Inc.SM
Member Services Department
9045 River Road, Ste 200
Indianapolis, IN 46240
1-800-553-8933
1-800-743-3333 (TDD for hearing impaired)
Website: www.advantageplan.com

SECTION 14: ANTI-FRAUD POLICY STATEMENT

ADVANTAGE is committed to the fight against fraud and corruption. *ADVANTAGE* employees, management and Directors refrain from conduct that may violate the fraud and abuse laws. These laws prohibit:

- direct, indirect or disguised payments in exchange for the referral of patients;
- the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and

- making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

Employees, *members, providers* and contractors can provide valuable information to alert *ADVANTAGE* to possible fraud and abuse issues. Therefore, *ADVANTAGE* has established reporting mechanisms to ensure timely identification and resolution of issues or suspicions of fraud. We have contracted with FPV, Inc. to establish and manage an external hotline. The hotline will allow employees, *members, providers*, and contractors to report suspicion of fraud anonymously or in confidence and without fear of retaliation. Individuals who report problems and concerns in good faith via the hotline will be protected from any form of retaliation. All those who are employed in the external hotline operation are expected to act with utmost discretion and integrity in assuring that information received is acted upon in a reasonable and proper manner. Each FPV employee involved with the *ADVANTAGE* hotline will be required to sign a Confidentiality Agreement.

You may call the *ADVANTAGE* Hotline at **1-888-333-9576**. Our current call center hours are Monday – Friday from 8am – 9pm, and Saturday from 8am – 6pm. During off-hours *ADVANTAGE* has an automated voicemail system and returns all calls on that line.

SECTION 15: GLOSSARY OF TERMS

This section defines terms that have special meanings. The word or phrase is defined in this section or elsewhere in this *Certificate*.

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) - Corporation *authorized* to do business in Indiana, licensed under the Indiana Health Maintenance Organization law, which has a C*ontract* with *your* employer *group* (*Group*) to arrange for health care services for m*embers* as described in this *Certificate*.

AGREEMENT or GROUP SERVICE AGREEMENT or CONTRACT or GROUP CONTRACT - The *Contract*, including any *amendments* or riders agreed to by *ADVANTAGE* and *your Group* that expresses the rights and obligations of both parties. It also describes the costs, procedures, benefits, conditions, limitations, *non-covered services*, and other obligations to which *members* are subject to under *ADVANTAGE*'s health maintenance organization.

AMBULANCE – A specially designed and equipped vehicle or aircraft that is used for the purpose of responding to *emergency* life-threatening situations and providing *emergency* transportation services. An *ambulance* must be certified as such in the state(s) in which it operates.

ANNUAL BENEFIT MAXIMUM - A maximum number of visits, days, sessions, or specific dollar amount that will be provided per *covered service*, per *member*, and per *calendar year*.

AT HOME POST DELIVERY CARE - Health care services provided to a woman at her residence, including, but not limited to: parent education, assistance and training in breast or bottle feeding; and any maternal and neonatal tests routinely performed during the usual course of *inpatient* care for the woman or her newborn child, including collection of an adequate sample for the hereditary and metabolic newborn screening. Services may be provided by: a *physician*; a *RN*; or an advanced practice nurse whose scope of practice includes providing postpartum care in the area of maternal and child health care. The *At home post delivery care* visit must be provided within 48 hours after the mother and newborn child are discharged from the *hospital*. At the mother's discretion, the visit may occur in the *participating provider*'s office.

AUTHORIZATION, AUTHORIZED SERVICES, PRIOR AUTHORIZATION, OR PRE-CERTIFICATION – A *covered service* which has been *authorized* in advance by *ADVANTAGE*.

BEHAVIORAL HEALTH NETWORK - A *participating behavioral health network* of mental health and substance abuse *providers* affiliated with a *member's* assigned *PCP*. The *participating provider network* is responsible for arranging behavioral health services, coordination of care, and case management.

BENEFIT PERIOD – A *benefit period* begins on the first day *you* go to a Medicare-covered *skilled nursing facility*. The *benefit period* ends when *you* have not been an *inpatient* at any *skilled nursing facility* for 60 days in a row. If *you* go to a *skilled nursing facility* after one *benefit period* has ended, a new *benefit period* begins. There is no limit to the number of *benefit period*s *you* can have. The type of care *you* actually receive during the stay determines whether *you* are considered to be an *inpatient* for *skilled nursing facility* stays.

BIOLOGICAL or BIOPHARMACEUTICAL DRUG means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. *Biological* or *biopharmaceutical products* typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct *physician* involvement, and significant *member* education. These services must be *authorized* by *ADVANTAGE*.

BRAND-NAME (DRUG) means a drug that has been manufactured under a patent and in accordance with the approval for the Food and Drug Administration (FDA).

CARRIER – An underwriter or insurer.

CALENDAR YEAR means the twelve-month period beginning on January 1 and ending on December 31.

CERTIFICATE OF COVERAGE (CERTIFICATE) - The document given to *you*, that describes both *your* and *ADVANTAGE*'s rights and duties. It includes the schedule of benefits and any *options*, amendments, riders or attachments to this document.

COINSURANCE and COPAYMENT – The amount a *member* must pay directly to a *participating provider* of *covered services* for those services and supplies. A *member* generally must pay this amount at the time *covered services* are received.

CONTRACT YEAR means the duration of *covered benefits* described in the A*greement* between *ADVANTAGE* and the *Group* and described on the cover page of this *Certificate*.

COORDINATION OF BENEFITS (COB) - An attempt by one of *ADVANTAGE*'s *participating provider's* and/or *ADVANTAGE* to recover the cost of care provided to a *member* from a third party. The third party may be another insurer, such as automobile, home, business, and/or renter, service plan, government third party payor, or other organization, which also provides *coverage* for a *member*'s health care needs. *Coordination of benefits* is subject to any limitations imposed by this *Certificate* or another applicable policy preventing such recovery.

COSMETIC – A service that involves physical appearance, but is not *medically necessary* and does not correct or materially improve a physiological function.

COVERED SERVICES or COVERAGE – Those services or supplies that a *member* is entitled to under this *Certificate*, if the services are *medically necessary* and *the member* has met all other requirements of this *Certificate.* The *Agreement* between *ADVANTAGE* and the *Group*, this *Certificate*, limit what *ADVANTAGE* will pay for some services and supplies. When *ADVANTAGE* says it will "Cover" a service or supply that means *ADVANTAGE* will treat the service as a *covered service*.

CUSTODIAL CARE - Care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. *Custodial care* is not covered under this *Certificate*.

DEDUCTIBLE - The specific dollar amount of charges for *covered services* that *you* must incur before certain *covered services* will be paid.

DURABLE MEDICAL EQUIPMENT (DME) - Rental or purchase of *DME* is covered only when *medically necessary* and *authorized* by ADVANTAGE. *DME* can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of *illness or injury* and is suitable for use in *member's* home. Examples of *DME* include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, *hospital* beds, monitoring devices, oxygen-breathing apparatus and insulin pumps.

EFFECTIVE DATE OF COVERAGE – The date when *your coverage* begins under this *Certificate*.

ELIGIBLE DEPENDENT or DEPENDENT - means a person of the *subscriber's* family: who meets the eligibility requirements of the *Group* and eligibility requirements listed in this *Certificate*; for whom the *subscriber* has applied for membership; and for whom *premiums* have been paid by *Group* and/or *subscriber*. To be an *eligible dependent,* a person must meet *ADVANTAGE*'s *service area* requirement, (see *Service Area* definition) and be either: the legal *spouse* of the *subscriber*; a natural or adopted unmarried *dependent* child of the *subscriber*; other individual determined to be eligible for enrollment by the *Group*; or an unmarried *dependent* child for whom the *subscriber* is the legal guardian or foster parent or has been ordered by a Court or administrative order to provide health care *coverage.;*

A *subscriber* and *spouse* working for the same *Group* cannot be both *subscriber* and *dependent.*

EMERGENCY SERVICES - Services provided due to a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a body organ or part of the individual.

EXPERIMENTAL or INVESTIGATIONAL - Any intervention (treatment, procedure, facility, equipment, drug device, service, or supply): that meets one or more of the following criteria:

- Intervention that is not generally and widely accepted in the practice of medicine in the U.S.; and whose effectiveness is not documented in peer-reviewed articles in medical journals published in the U.S. For interventions to be considered effective, journal articles should indicate that the intervention is more effective than other available, or, if not more effective, is safer or less costly.

- Interventions that are considered *experimental* or *investigational* by:
  - the U.S. Department of Health and Human Services;
  - the National Institute of Health; or

- any of their subsidiary agencies

• Drugs or medical devices *biological* products, or some combination thereof that the U.S. Food and Drug Administration (FDA) has not cleared or approved for commercial distribution, or that do not have other governmental agency approval as required by law.

• Use of an FDA cleared or approved drug, medical device, *biological* product or some combination thereof for a use: (1) that FDA has not cleared or approved and that would otherwise require such clearance or approval (i.e., an 'off-label' use); and (2) the effectiveness of which has not been documented in peer-reviewed articles in medical journals published in the U.S. For used of this type to be considered effective, such articles should indicate that using the drug, medical device, biological product, or some combination thereof for he particular use at issue is more effective than other products available for the proposed use, or, if not more effective, is safer or less costly.

FORMULARY - *ADVANTAGE* utilizes a prescription drug *formulary*. A *formulary* is a list of preferred *generic* and *brand name* prescription medications that have been approved by the Food and Drug Administration (FDA).

GENERIC (DRUG) means a copy of a *brand-name drug* for which the patent has expired. The *generic drug* may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the *brand-name drug*. The same quality and safety standards that apply to *brand-name drug*s also apply to the *generic* form. The FDA sets standards and reviews all *generic* medications before being marketed.

GRIEVANCE is a written or oral complaint submitted in accordance with the formal *grievance* procedure of *ADVANTAGE* by or on behalf of a *member* regarding any aspect of *ADVANTAGE* relative to the *member* that expresses dissatisfaction regarding the:

• Availability, delivery, appropriateness or quality of health care services
• Handling or payment of claims for health care services or;
• Matters pertaining to the contractual relationship between:
  i) a *member* and *ADVANTAGE*; or
  ii) a *Group* or individual C*ontract* holder and *ADVANTAGE*;
• Any concerns regarding confidentiality of information
and for which the *member* has a reasonable expectation that action will be taken to resolve or reconsider the matter that is subject of dissatisfaction.

GROUP means the *subscriber's* employer who has *contract*ed with *ADVANTAGE* to provide *member* and *eligible dependent*'s health benefits.

HEALTH PROFESSIONAL - A professional engaged in the delivery of health services who is licensed, where required, under the laws of the jurisdiction where services are delivered and operating within the scope of his/her license.

HOME HEALTH SERVICES - Health services delivered in a *member's* home setting and provided by an organization licensed by the State and operating with the scope of its license.

HOSPICE CARE OR FACILITY – a health care facility or a system of professional home visits and supervision, for supportive care of the *terminally ill.*

HOSPITAL - An acute care facility duly licensed in the jurisdiction where services are rendered.

ILLNESS - A sickness or disease and all related conditions and recurrences. The term *illness* includes pregnancy and all related conditions.

INJURY - An accident to the body that requires medical or surgical treatment.

INPATIENT - Confinement as a bed-patient for 24 hours or longer in a *hospital, SNF*, or *hospice facility.*

LATE ENROLLEE – As described in this *Certificate*, is a *subscriber* or *eligible dependent* who did not request enrollment with *ADVANTAGE*: during the initial enrollment period in which he/she was first entitled to enroll; or during any special enrollment period, and as described in this *Certificate.*

LICENSED PRACTICAL NURSE - Person who has been licensed by a State Board of Nurse Examiners or other state authority, and how is legally entitled to place the letters "LPN" after his name.

LOW PROTEIN MODIFIED FOOD PRODUCT means a food product that is (1) specially formulated to contain less than one (1) gram of protein per serving; and (2) intended to be used under the direction of a *physician* for dietary treatment of an *inherited metabolic disease*.

MAXIMUM ALLOWABLE AMOUNT – The amount that *ADVANTAGE* determines is the maximum payable for *Covered services you* receive, up to but not exceed charges actually billed. For a non-*participating provider* the *Maximum allowable amount* is the lesser of the actual charge or the standard rate under the contracted used with *participating providers.* The *Maximum allowable amount* is reduced by any penalties for which a *member* is responsible under the terms of this *Certificate.*

MEDICAL FOOD means a food that is (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by a medical evaluation; and (2) formulated to be consumed or administered internally under the direction of a *physician*.

MEDICALLY or *CLINICALLY NECESSARY* is defined as:

1. appropriate for the symptoms, diagnosis, or treatment of the medical condition; and
2. provided for the diagnosis or direct care and treatment of the medical condition; and
3. within standards of good medical practice within the organized medical community; and
4. not primarily for the convenience of the member's *physician* or another provider; and
5. not otherwise subject to *non-covered services* under this *Certificate* ; and
6. the most appropriate procedure, supply, equipment, or service that can safely be provided. The most appropriate procedures, supplies, equipment, or service must satisfy the following requirements:

   i. there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the member with the particular medical condition being treated than other alternatives; and
   ii. generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
   iii. for *hospital* stays, acute care as an *inpatient* is necessary due to the kind of services the member is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an *outpatient* or in a less intensified medical setting

The fact that a provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies *medically necessary*.

MEMBER (you, your) - An eligible person enrolled in *ADVANTAGE*'s health plan, as a *subscriber* or *eligible dependent*.

NON-COVERED SERVICES are those services not covered under this *Certificate* and are listed as *non-covered services* in this *Certificate*.

OPEN ENROLLMENT PERIOD - Period of time established by *ADVANTAGE* and the *Group* during which eligible employees and their *eligible dependents* may enroll as new *members*.

OPTION - An addition or amendment to the *Agreement* indicating any additional *covered services* and the corresponding *member copayment*, *coinsurance*, and maximum benefit limits (if applicable).

OUT-OF-POCKET MAXIMUM - Maximum *coinsurance* amount for *covered services*, per *member* and per family per *calendar year*.

OUTPATIENT - Member who receives medical services, but is not an *inpatient*.

PARTIAL HOSPITALIZATION - A structured mental health and/or substance abuse treatment program with sessions of three hours or longer.

PARTICIPATING or CONTRACTING HOSPITAL – A *hospital* that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHARMACY - A pharmacy or organization of pharmacies that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHYSICIAN - A *physician* who contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PROVIDER - A *health professional* or other entity that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PCP or **PRIMARY CARE PHYSICIAN** – A *participating physician* selected by the *member* to be his/her primary health care *provider*. *Primary care physicians* may include Family or General *Physicians*, Internists, Pediatricians and OB-GYN's.

PHYSICIAN - An appropriately licensed *physician* or surgeon.

PHYSICIAN NETWORK, **PROVIDER NETWORK** means organized *group* of *physician*s, facilities and *health professionals* contracted with that has entered into *a* contract with *ADVANTAGE*. A *physician network* has as its primary purpose the delivery, or the arrangement for the delivery, of *covered services*.

POLICY MAXIMUM or CONTRACT MAXIMUM or AGREEMENT MAXIMUM – Total lifetime maximum dollar amount payable for *Covered services* the *member* receives under the *Agreement* issued to the *Group*, including any renewals, endorsements,

amendments or addendums thereto. If there is a lapse in *coverage*, the *policy maximum* applies to all benefits received both before or after the lapse.

PREMIUM – The total payment, including any contributions from *subscribers* or late charges, that the *Group* pays *ADVANTAGE* to maintain *coverage.*

PRE-EXISTING MEDICAL CONDITION – A physical or mental condition for which medical advice, diagnosis, care or treatment is recommended or received up to six (6) months prior to coverage *effective date*. Pregnancy is not considered a *pre-existing medical condition*. Genetic information may not be considered a *pre-existing medical condition* if there is no specific diagnosis of a current disease or medical problem related to the genetic test. A pre-existing medical condition may not apply to a newly born dependent child enrolled within 31 days of date of birth or a dependent child who is adopted by, or placed for adoption with, the subscriber and enrolled within the first 31 days of placement with the subscriber or within 31 days of the date of entry of the order granting the adopting parent custody of the child for purposes of adoption.

PRE-EXISTING MEDICAL CONDITION EXCLUSION PERIOD – The period of time during which services relating to *pre-existing medical conditions* are not considered *covered service*s under this *Certificate*. The *pre-existing exclusion period* is six (6) months from the effective date of coverage with *ADVANTAGE*, less the number of months exhausted under *prior creditable coverage.*

PRIOR CREDITABLE COVERAGE – C*reditable coverage you* had prior to *your effective date* with *ADVANTAGE* that was continuous. For the purpose of this section, "continuous" means *coverage* that was not interrupted by a break of 63 or more days in a row. There can be more than one break, but no single break can be 63 or more days in length. Proof of *prior creditable coverage* is determined by a Certificate of *Creditable Coverage*, which is a written Certificate of *your* prior *coverage* provided to *you* by *your* prior health *carrier*. The *Certificate* must identify *you* as the covered person, period of *coverage*, and waiting periods (if any).

PROPER REFERRALS - Process where a *member's physician* directs the *member* to seek or obtain *covered services* from another *participating or* <u>non</u>*-participating health professional* or *inpatient facility* subject to ADVANTAGE's *pre-certification* requirements.

PROVIDER - Any *hospital, physician,* pharmacy, *SNF*, individual, organization, or agency that is licensed to provide professional services within the scope of that license or certification.

PROVIDER DIRECTORY – A document listing *ADVANTAGE*'s *participating providers* available to *you* under this *Certificate* .

QUALITY IMPROVEMENT ("QI") COMMITTEE - Committee of *physicians and other health professionals* selected and approved by the *provider network* and/or *medical Group* to disseminate and maintain professional standards.

REGISTERED NURSE (RN) - A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "RN" after his name.

RENEWAL DATE - Date on which the *Agreement* will be renewed.

SECOND OPINION - Medical or surgical opinion that is provided by a *physician*, to reevaluate the condition. The *second opinion* is made with prior *authorization* from *ADVANTAGE*.

SERVICE AREA means the geographical area where the *member* must work or reside to be eligible to enroll, which **is 30 air** miles of the office of the *member's* assigned *PCP*.

SKILLED NURSING FACILITY or **SNF** - Institution, or a distinct part of an institution, which:

- is duly licensed in the state of Indiana; is regularly engaged in providing 24-hour skilled care under the regular supervision of a *physician* and the direct supervision of a *RN*;
- maintains a daily record on each patient; and
- provides each patient with active treatment of an *illness* or *injury*, or related rehabilitation, in accordance with existing standards of medical practice for that condition.

A *SNF* does not include any institution or portion of any institution that is primarily for rest, the aged, non-skilled care, or care of mental diseases or substance abuse.

SPECIALTY CARE PHYSICIAN (SCP) - A *physician* who has an identified specialty other than a family practice, internal medicine, or pediatrics; and who is not acting in the role of a *PCP* to the *member* at the time services are provided. Examples of *SCPs* would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc.

SPOUSE - *Subscriber*'s legal *spouse*.

SUBSCRIBER (you, your) - An employee of the *Group*, who resides and/or works in Indiana (the geographic area in which *ADVANTAGE* is licensed), who meets the eligibility requirements of the *Group*, who has enrolled for coverage with ADVANTAGE, and for whom *premiums* have been paid by the *Group*. A *subscriber* and *spouse* working for the same *Group* cannot be both *member* and *dependent.*

TERMINALLY ILL OR TERMINAL ILLNESS - A *physician* has given a prognosis that a *member* has six months or less to live.

URGENT CARE - Urgently needed services or *urgent care* services are instances when a *member* needs *covered services* urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen *illness* or *injury*;
- while outside of the *service area*;
- for which treatment cannot be delayed until the *member* returns to the *service area* without the *member*'s condition growing much worse.

Urgently needed services are determined by medical condition not the place of treatment.

WELL CHILD CARE - A clinical check of a child for the purpose of assessing physical status and detecting abnormalities, in the absence of symptoms. *Well child care* includes pediatric immunizations including, but not limited to: diphtheria, pertusis, small pox, measles, mumps, rubella, poliomyelitis, and tetanus.

WOMAN AT RISK - A woman who meets at least one of the following descriptions:
- a woman who has personal history of breast cancer;
- a woman who has a personal history of breast disease that was proven benign by biopsy;
- a woman whose mother, sister, or daughter has had breast cancer; or

YOU or YOUR or MEMBER - An *eligible person* enrolled in *ADVANTAGE*'s health plan, as a *subscriber* or *eligible dependent.*

YOUNG ADULT – means a person who, regardless of marital status:
(1) between the ages of 19 and 24; and
(2) is not eligible for coverage as an eligible dependent under the subscriber contract; and
(3) meets one of the following criteria:
(A) is the natural or adopted child of a subscriber; or
(B) is the stepchild, grandchild, other blood relative of a subscriber and the subscriber pays more than 50% of the person's total support; or
(C) the subscriber is the persons' legal guardian and the subscriber pays more than 50% of the person's total support.

Family Planning Services Rider

The Certificate is amended as follows. If there is any conflict between the Certificate and this Rider, this Rider shall prevail. The effective date of this Rider is the date shown on the Contract.

Ethical and Religious Directives: ADVANTAGE Health Solutions, Inc.[sm] (ADVANTAGE) is an institution operated in accordance with The Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide, and no provision of a Policy shall be construed so as to require it to provide, services that are inconsistent with the medical ethics or precepts of the Catholic Church.

Family Planning Services means:

1. birth control drugs that require a prescription
2. birth control devices that require a prescription, including the removal of such devices; and
3. voluntary sterilization

FAMILY PLANNING SERVICES

ADVANTAGE is owned by Catholic organizations. Because of this, ADVANTAGE cannot provide services that are not in accord with the Ethical and Religious Directives. Coverage for Family Planning services will be provided and claims will be administered through a 100% reinsurance program through:

Cyrca Insurance Management
303 Congressional Blvd.
Carmel, IN 46032
1-800-510-0225

50% coinsurance up to $2,500 lifetime maximum for all Family Planning Services except for prescription drugs for birth control. Prescription drugs for birth control are excluded from the lifetime maximum. The applicable copayment for prescription drugs for birth control is equal to the amount of the outpatient prescription drug copayment stated in the Certificate if member is entitled to pharmacy benefits.

EXCLUSIONS

1. Abortion, except when the life of the mother would be endangered if the fetus were carried to term.

2. Birth control drugs or devices that do not require a prescription. For example:

   a. condoms; and

   b. foams, jellies, or creams used to kill sperm.

3. Oral and injectable drugs which are used primarily for the purpose of treating infertility. (For example, Clomid, Metrodin, and Pergonal.)
4. Cyropreservation of ova, sperm, or fertilized eggs.

5. Any procedure which involves destroying human embryos.

6. Artificial insemination, except by the covered person's spouse.

7. Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), or in-vitro or in-vivo fertilization.

8. Use of a surrogate for any reason.

9. Treatment for infertility.

10. Oral drugs for the treatment of impotence.

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:

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.

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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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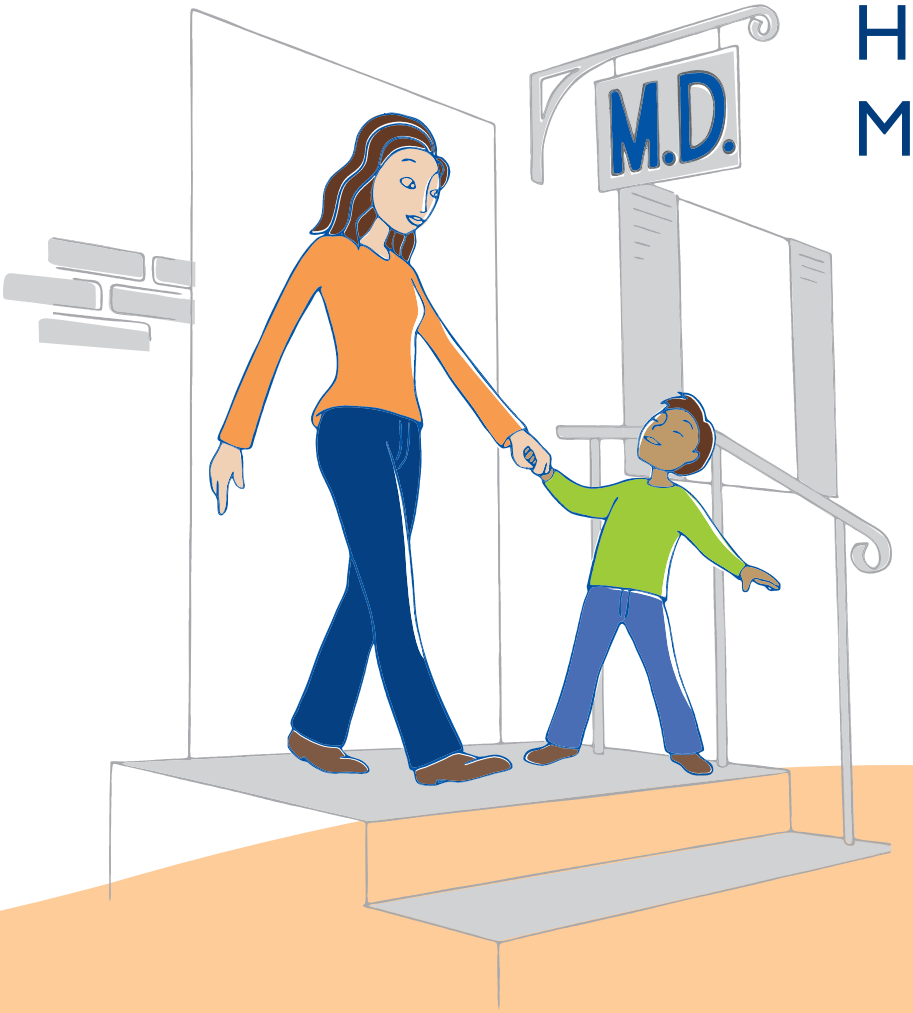
MDwise



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.

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

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.

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.

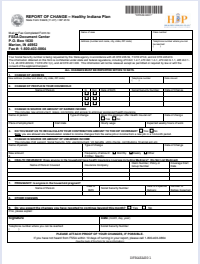
We want to provide high quality service to you. So, here is our promise to you:
- If you have a problem, we will be here to listen.
- We will do our best to fix the problem for you.

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

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September 10, 2010

MEMORANDUM

To: Anne Murphy

From: Caroline M. Brown and Rachel Grunberger

Re: Covering New Eligibles under HIP

The State of Indiana has asked our opinion as to whether it may use the Healthy Indiana Plan (HIP) as the vehicle for covering the population newly eligible for Medicaid under the Affordable Care Act (ACA). In particular, you have asked whether, in extending HIP to cover ACA's "new eligibles," Indiana can continue to use the Personal Wellness and Responsibility (POWER) Account feature of HIP, which has proven very successful. For the reasons given below, we believe that it can.

In addition, we do not see any barrier to the State moving the HIP program from an 1115 demonstration project to the state plan. However, were the State to continue HIP as a demonstration project, the waiver should be amended to cover newly eligible childless adults as a "hypothetical" Medicaid population for purposes of budget neutrality. This would permit the State to recapture the portion of its disproportionate share hospital (DSH) allotment that is currently diverted to the waiver to satisfy budget neutrality rules.

Background: HIP currently operates under a Section 1115 waiver to provide coverage to certain uninsured adults earning less than 200% of the federal poverty level (FPL).

The adults covered by HIP fall into two categories. The "HIP caretakers" are those who could be covered under Medicaid as caretakers of Medicaid-eligible children. HIP covers adults with incomes or assets above the AFDC income limit set forth in the state plan. (The State plan AFDC income limit is approximately 23% of the FPL and the asset limit is $1,000.) "HIP adults" are uninsured non-custodial parents and childless adults who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200% of the FPL, with no resource limit. For purposes of budget neutrality (a central element of an 1115 waiver), the HIP caretakers are treated as a "hypothetical" population – i.e., one that could be in the state plan but instead is covered under the waiver. The HIP adults are treated as a pure demonstration population. The costs of their coverage cannot exceed the savings that the State has demonstrated elsewhere in the demonstration project. The savings come from a portion of the

DSH allotment that the State does not spend on hospitals, and managed care savings from the Hoosier Healthwise managed care program.

The centerpiece of HIP is the POWER Account, which is modeled on a traditional Health Savings Account (HSA). HIP provides a POWER Account valued at $1,100 per adult to pay for initial medical costs. The POWER Accounts are funded with state, federal, and enrollee contributions. Enrollee contributions are determined on a sliding scale based on the enrollee's income, but do not exceed 5% of an enrollee's gross family income. The State (with federal financial participation) funds the difference between the enrollee's contribution and the $1,100 account value. In calculating the 5% cap, the State takes into account the cost-sharing for all family members (e.g., CHIP premiums for children, POWER account contributions for other HIP participants in the family, Medicare cost-sharing, etc.).

Enrollees use the POWER Accounts to pay for the cost of health care services until the $1,100 threshold is reached. (HIP also provides $500 in "first dollar" preventive benefits at no cost to HIP members; these benefits are exempt from the requirement to use POWER Account funds for the first $1,100 of medical costs.) Once the $1,100 threshold is met, a HIP managed care organization (MCO) or Enhanced Services Plan (for enrollees with identified high-risk conditions) provides coverage for medical services up to an annual maximum amount.

The POWER Account is designed to encourage preventive care, the appropriate utilization of health care services, and personal responsibility. Three years into the program, the State is already seeing evidence that the POWER Account is furthering those goals, with lower emergency room usage in HIP than other programs; over 98% of HIP enrollees making their POWER Account contributions on time; over 76% of HIP enrollees receiving their required preventative services; and over 94% of HIP enrollees reporting satisfaction with the program.

New Eligibles and Benchmark Coverage. Beginning in 2014, the ACA will require States to cover individuals with incomes up to 133% FPL (plus 5% disregard) who are not otherwise eligible under current Medicaid categories. The new eligibles must be provided with a "benchmark" benefit package.

Section 2001 of the ACA mandates that medical assistance provided to the new eligibles must consist of benchmark coverage described in Section 1937(b)(1) of the Social Security Act or benchmark-equivalent coverage described in Section 1937(b)(2) of the Act, unless the individual is exempt from mandatory enrollment in a benchmark benefit plan. Moreover, the benefits package provided to new eligibles must include the "essential health benefits" available under the State Health Insurance Exchanges. *See* ACA §§ 2001, 1302, 10104. The ACA requires the Secretary of the Department of Health and Human Services (Secretary) to define the essential health benefits, which must include at least the following general services:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health benefits and substance use disorder services

- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management; and
- pediatric services including oral and vision care.

ACA §§ 1302, 10104.

Section 1937(b)(2)(A) of the Social Security Act requires benchmark-equivalent plans to cover "items and services" within each of the following categories: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunization. In addition, "[o]ther appropriate preventive services, as designated by the Secretary," must be covered. Social Security Act § 1937(b)(2)(A).

As of July 1, 2010, 42 C.F.R. § 440.335 requires that benchmark-equivalent plans also cover:

- emergency services; and
- family planning services, supplies, and other appropriate preventive services, as designated by the Secretary.

75 Fed. Reg. 23,068, 23,103 (Apr. 30, 2010).

Moreover, although not required by Section 1937 of the Social Security Act, CMS has interpreted certain changes to the statute made by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. 111-3, to require that the following be included:

- Early Periodic Screening, Diagnosis, and Treatment Services
- non-emergency medical transportation.

Id. at 23,076, 23,077.

HIP and Benchmark Coverage. As set forth in the Section 1115 waiver, HIP currently offers the following benefits:

- Inpatient Facility
  - medical/surgical
  - mental health/substance abuse (covered same as any other service)
  - skilled nursing facility (60-day maximum)
- Outpatient Facility
  - surgery
  - emergency room (co-payment for non-emergency services)
  - urgent care
  - physical/occupational/speech therapy (25-visit annual maximum for each type)
  - radiology/pathology

    - pharmacy and blood
    - cardiovascular
- Professional Services
    - inpatient/outpatient surgery
    - inpatient/outpatient/ER visits
    - office visits/consults
    - preventive services (at least $500 annual first dollar coverage)
    - physical/occupational/speech therapy (25-visit annual maximum for each type)
    - cardiovascular
    - radiology/pathology
    - outpatient mental health/substance abuse (covered the same as any other illness)
- Ancillary Services
    - prescription drug (brand name drugs not covered where generic substitute is available)
    - home health, including hospice/home IV therapy (excludes custodial care; includes hospice)
    - ambulance (emergency ambulance transportation only)
    - durable medical equipment/supplies/prosthetics
    - family planning services (excluding abortion or abortifacients; includes contraceptives and sexually transmitted disease testing)
    - lead screening services (ages 19 & 20 only)
    - hearing aides (ages 19 & 20 only)
    - Federally Qualified Health Center and Rural Health Center services (subject to HIP benefit coverage limits)
    - disease management services

The State's Section 1115 demonstration project does not expressly state that HIP is "benchmark" coverage. However, in order for the Secretary to have approved HIP caretakers as a "hypothetical" population that could have received benefits under the state plan, CMS necessarily concluded that the HIP benefits could have been provided under the state plan as a benchmark or benchmark equivalent package. (One of the benchmarks is "Secretary-approved coverage.")

Since the waiver was first approved, however, both Congress and CMS have stipulated that certain benefits, not included in HIP, must be included in a benchmark or benchmark equivalent package. Therefore, if HIP is to be the benchmark package for the new eligibles, we believe that certain benefits will have to be added to the HIP package. Based on the requirements described above, Indiana likely will have to add non-emergency transportation and maternity care services to the HIP benefits package, as well as dental and vision for any HIP participants under age 21. The State also will have to ensure that the package includes any "essential health benefits" defined by the Secretary in future regulations. But given the relative consistency between the existing HIP benefits package and the benefits currently required for benchmark-equivalent plans, we believe Indiana can use the HIP benefits package (with minor modifications) to cover the new eligibles.

HIP and the POWER Account. We believe that Indiana can continue to use the POWER Accounts as the central feature of the HIP program. We have not identified any provision in Title XIX that would prohibit the State from giving enrollees greater control of their health care decisions or encouraging positive health behaviors by requiring use of the POWER account.

A key question is whether enrollees could continue to be required to make contributions to the POWER account once they were a Medicaid population, rather than, as currently, a demonstration population under the waiver. We believe there is a persuasive argument that the contributions could continue at current levels, despite Medicaid's limitations on cost-sharing, including the prohibition against premiums for individuals with family income below 150% of the FPL. *See* 42 C.F.R. §§ 447,71, 447.72. As described below, (1) the POWER account contributions comply with Medicaid's 5% cap on aggregate cost-sharing; and (2) POWER account contributions are not premiums.

POWER Accounts and 5% Aggregate limit. While Medicaid cost-sharing rules vary by income level, service, and eligibility group, in general some cost-sharing is permissible, provided that, in the aggregate, it does not exceed 5% of family income. HIP complies with this requirement. For the "newly eligible" population up to 138% FPL for whom HIP would be a benchmark package, POWER account contributions are capped at 4% of family income.

Under HIP, as it is currently structured, the sliding scale for enrollee contributions to the POWER Account is as follows:

Annual Household Income	**Maximum Power Account Contribution**
All enrollees at or below 100% FPL	No more than 2% of income
All enrollees above 100% through 125% FPL	No more than 3% of income
All enrollees above 125% through 150% FPL	No more than 4% of income
HIP Caretakers above 150% through 200% FPL	No more than 4.5% of income
HIP Adults above 150% through 200% FPL	No more than 5% of income

The regulations require that the cost sharing for *all* individuals in the family be under the 5% cap. It is our understanding that the POWER account contributions are already calculated in this manner and that, for example, the amount that a family pays in CHIP premiums is deducted from the amount that is to be contributed to the POWER account. Therefore, it does not appear that any changes to POWER account contribution levels would have to be made in order to be compliant with Medicaid cost-sharing rules.

However, the regulations also require that the income be measured on a monthly or quarterly period (as specified by the State). To the extent that HIP looks at annual income, it

may need to adjust to a monthly or quarterly calculation, although we believe that is a requirement that the Secretary can waive under Section 1115.

POWER Account Contributions are Not Premiums. In addition to the 5% overall cap, Medicaid regulations include limits on certain types of cost-sharing, including premiums. Premiums may not be charged to individuals with income below 150% of the FPL, which would include all new eligibles. We do not believe an enrollee contribution to the account is a "premium," as that term is understood in both the Medicaid and traditional HSA context, and therefore this limitation should not prevent Indiana from requiring POWER account contributions.

Section 1916A of the Social Security Act defines "premium" to include "any enrollment fee or similar charge." But the enrollee contribution to the POWER Account is not an "enrollment fee;" rather, it is a contribution towards the $1,100 amount in the account. In that way, it is closer to either a deductible or co-insurance (although, unlike those two, it does not relate to a particular service at the time it is paid). There is no prohibition against deductibles or co-insurance (or any cost-sharing other than premiums) for individuals with incomes below 150% of the FPL (except for children, pregnant women, and institutionalized individuals, who would fall into Medicaid eligibility categories other than the new eligibles).

Section 1938 of the Social Security Act, which authorizes state demonstration programs involving "Health Opportunity Accounts" (HOAs), refers to the amounts paid into HOAs as "contributions," not premiums. HOAs are modeled on traditional HSAs, with contributions coming from States, charitable organizations, or other persons or entities that may transfer funds to the State without violating the donation rules of Section 1903(w). There is no indication in Section 1938 or CMS guidance on HOAs that the contributions are in the nature of premiums or enrollment fees. *See* Social Security Act § 1938; *see also* CMS Letter to State Medicaid Directors No. 07-001 (Jan. 10, 2007).

Moreover, in the traditional HSA context, there is a clear distinction between use of funds contributed to an HSA and payment of health insurance premiums. *See* Internal Revenue Service, *Publication 969, Health Savings Accounts and Other Tax Favored Health Plans* (2009), *available at* http://www.irs.gov/publications/p969/ar02.html (describing restrictions on the use of HSA funds to pay insurance premiums); *see also* U.S. Dep't of Treasury, *HSA Frequently Asked Questions*, available at http://www.ustreas.gov/offices/public-affairs/hsa/faq_using.shtml (stating that an individual can only use an HSA to pay health insurance premiums if the person is collecting federal or state unemployment benefits, or if the individual has COBRA continuation coverage through a former employer). The POWER Account is modeled on the traditional HSA and, accordingly, the contributions to a the POWER Account should be viewed as distinct from premiums or enrollment fees.

In addition, Congress has recognized, in the context of HOAs, that programs designed around HSA-like accounts have the capacity to yield tremendous benefits, such as creating patient awareness of the high cost of medical care, providing incentives to patients to seek preventive care services, reducing inappropriate use of health care services, and enabling patients to take responsibility for health outcomes. *See* Social Security Act § 1938. And, in the HOA context, States have significant flexibility with respect to cost sharing. *See id.* (providing that the

requirements of Sections 1916 and 1916A do not apply to HOA demonstration programs). Taking the position that contributions to the POWER Account are premiums -- and therefore are prohibited for individuals below 150% FPL -- would be inconsistent with these policy objectives.

Finally, we note that the HIP demonstration project documents include a statement that among the Title XIX requirements "not applicable" to HIP is Section 1916(a)(1), "to the extent necessary to enable Indiana to charge premiums for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP adults)." Because the enrollment fee is never referred to as a "premium" in the terms and conditions, we believe this can be interpreted as a determination, by CMS, that the POWER account contributions are not premiums and therefore the prohibition on premiums is "not applicable" to the HIP program.

HIP and Retroactive Eligibility. Like many 1115 waivers, HIP has a waiver of the provision requiring Medicaid coverage for the three-months prior to application, if the individual met eligibility requirements. Nothing in ACA would prevent continued waiver of that provision. However, HIP would have to continue as an 1115 waiver and not under the state plan.

HIP and Budget Neutrality. Even if the State continues HIP under the 1115 demonstration project authority (rather than under the state plan), once the HIP adults are Medicaid eligible, they can (like the HIP caretakers) be treated as a hypothetical population that "pays for itself" under budget neutrality principles (*i.e.*, counted as expenditures both under the waiver and in the without waiver baseline). This means that there is no longer a need to "pay" for this population with diverted DSH funds or Hoosier Healthwise savings.

One option that the State might want to consider is seeking an amendment to the waiver under which HIP adults are treated as Medicaid eligibles because the State could, hypothetically, become an "early expansion" State. ACA permits States to expand coverage to the new eligibles before 2014. As a practical matter, the State would not be in a position to enroll all the newly eligible HIP adults at the same time, but would have to control enrollment in order to permit provider capacity to grow and to provide sufficient time for orderly growth. This appears to have been envisioned by ACA, which permits States to phase in enrollment by income level. The build up of enrollment of HIP adults, as a hypothetical population, would let the State "hit the ground running" once the new eligibility criteria become mandatory on January 1, 2014.

Please let us know if you have questions about any of the foregoing.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 30, 2013

Debra F. Minott
Secretary
Family and Social Services Administration
402 W. Washington Street, P.O. Box 7083
Indianapolis, IN 46207-7083

Dear Ms. Minott:

Thank you for providing an update and supplement to the state's request to extend the Healthy Indiana Plan (HIP) section 1115 demonstration (Project Number 11-W-00237/5) that was submitted on February 13, 2013. As indicated in our February 25, 2013 response, the state's application previously did not include documentation with respect to the 30-day public comment and notice process that is required at the state level prior to submission to The Centers for Medicare & Medicaid Services (CMS). We have completed a preliminary review of the application, including supplemental material received April 15, 2013, and have determined that the state's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's extension request. The 30-day federal comment period, as required under 42 CFR 431.416(b), begins on April 30, 2013 and ends on May 30, 2013. The state's extension request is available at www.medicaid.gov.

We look forward to working with you and your staff to extend the state's demonstration. If you have additional questions or concerns, please contact your assigned project officer Wakina Scott, Division of State Demonstrations and Waivers, at (410) 786-0921, or at Wakina.Scott@cms.hhs.gov.

Sincerely,

/s/

Diane T. Gerrits
Director
Division of State Demonstrations and Waivers

cc: Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, CMCS
Verlon Johnson, ARA, CMS Chicago Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

February 25, 2013

Patricia Casanova
Director
Office of Medicaid Policy and Planning
Family and Social Services Administration
402 West Washington Street, PO Box 7083
Indianapolis, IN 46207-7083

Dear Ms. Casanova:

Thank you for your recent request to extend the state's Healthy Indiana Plan (HIP) section 1115 demonstration (Project Number 11-W-00237/5). The Centers for Medicare & Medicaid Services (CMS) received your extension request on February 13, 2013. After completing a preliminary review of your extension request we have determined that the state's extension request has not met the requirements for a complete extension request as specified under section 42 CFR 431.412(c). Specifically, at time of submission, the state had not included documentation with respect to the 30-day public comment and notice process that is required at the state level prior to submission to CMS.

As stated in the CMS final rule and the guidance on transparency in section 1115 demonstration projects issued on April 27, 2012, specific elements that need to be included in a state's extension request were not included. These items must be present in order for CMS to determine that the request is complete. Once an extension request has been determined complete, CMS can begin the official review process, including initiation of the 30-day federal public comment period. At this time, we will not be able to begin our 30-day federal public comment and notice process as specified under 42 CFR 431.416(b). Once we receive a revised extension request that includes the missing elements as described above, or explains how the current request addresses the missing element, we will conduct another preliminary review to determine if the revised request is complete. We will notify you of our determination no later than 15 days after receipt of your revised extension request.

We look forward to our continuing work with you and your staff, and are available to provide technical assistance as you revise the state's extension request. If you have additional questions

or concerns, please feel free to contact me directly or your Project Officer, Jessica Schubel at (410) 786-3032, or at Jessica.Schubel@cms.hhs.gov.

Sincerely,

/s/

Diane T. Gerrits
Director
Division of State Demonstrations & Waivers

cc: Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, CMCS
Verlon Johnson, ARA, CMS Chicago Regional Office

Ms. Anne Murphy
Secretary
Indiana Family and Social Services Administration
402 West Washington Street
Indianapolis, IN 46207

Dear Ms. Murphy:

We are pleased to inform you that the amendments to the Indiana section 1115 Medicaid demonstration project, entitled "Healthy Indiana Plan" (HIP) (Project No. 11-W-00237/5), submitted on October 23, 2008, April 15, 2009, and August 19, 2009, have been approved through December 31, 2012, upon which date, unless reauthorized, all waivers and authorities granted to operate this demonstration will expire. Approval of the demonstration project amendment is granted under section 1115 of the Social Security Act (the Act).

Our approval of these amendments is subject to the limitations specified in the list of approved waivers, expenditure authorities, and title XIX requirements not applicable. The State may deviate from the Medicaid State plan requirements to the extent those requirements have been specifically waived or listed as granted expenditure authority or title XIX requirements not applicable. The approval is also conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). All previously granted waiver and expenditure authorities are superseded by this approval, the enclosed STCs, and the waiver and expenditure authorities list.

The Centers for Medicare & Medicaid Services (CMS) is approving the State's requests to amend the demonstration to make the following changes:

(1) Add Two Cost Savings Projects
The State requested adding two types of cost savings projects to the list of savings projects—strategic purchasing agreements involving (1) incontinence supplies, and (2) hemophilia blood factor. These two cost savings projects have been added to the list of savings projects in the STCs.

(2) Raise the Limit on Nursing Facility Care from 30 to 60 Days
The State requested raising the limit on nursing facility care to 60 days. The STCs have been revised to allow for 60 days of nursing facility care.

(3) Use Additional Disproportionate Share Hospital (DSH) Allotment Made Available Through the American Recovery and Reinvestment Act of 2009 (ARRA) For Actual DSH Expenditures.
The State requested using the additional Federal fiscal year (FFY) 2009 and FFY 2010 DSH allotment available under ARRA to make payments for actual DSH expenditures rather than using the

allotment on the demonstration. The STCs have been revised to allow the State to use the additional ARRA DSH allotment for actual DSH expenditures.

(4) Carve-Out Pharmacy
The State requested making changes to the STCs to reflect the State's plan to carve pharmacy out from the capitated managed care plans that serve the Hoosier Healthwise and HIP populations beginning January 1, 2010. The STCs have been modified to reflect the State's plans to carve out pharmacy beginning January 1, 2010.

(5) Change Eligibility Parameters for the Enhanced Services Plan (ESP)
The State requested defining the qualifying conditions for ESP in the managed care contracts rather than in the STCs and defining the referral process in the managed care contracts. The STCs have been revised to reflect that the ESP qualifying conditions and the ESP-referral process are identified in the State's contracts with the managed care plans.

(6) *Cover Additional Non-Caretakers*
The State requested authority to lift the 34,000 member enrollment cap on HIP non-caretakers covered under the demonstration. The STCs have been revised to allow the State to cover up to 36,500 non-caretakers. If the State would like to cover more than 36,500 non-caretakers, the State would need to submit a formal amendment request and identify a sustainable way to cover these additional non-caretakers. CMS staff members are available to assist the State in working to identify a sustainable way to cover additional non-caretakers.

Written notification to our office of your acceptance of this award must be received within 30 days after you receive this letter. Your project officer is Ms. Julie Sharp. She is available to answer any questions concerning this demonstration project. Ms. Sharp's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-2292
Facsimile: (410) 786-5882
E-mail: Juliana.Sharp@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Sharp and to Ms. Verlon Johnson, Associate Regional Administrator in our Chicago Regional Office.
Ms. Johnson's contact information is as follows:

Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519

If you have questions regarding this correspondence, please contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

Charlene Frizzera
Acting Administrator

Enclosure

cc: Verlon Johnson, ARA, Region V
Alice Holden, State Representative

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00237/5**

TITLE: **Healthy Indiana Plan (HIP) Medicaid Section 1115 Demonstration**

AWARDEE: **Indiana Family and Social Services Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this Demonstration, be regarded as expenditures under the State's Medicaid title XIX State plan.

The following expenditure authorities shall enable Indiana to implement the Medicaid section 1115 Demonstration (Healthy Indiana Plan).

1. **Demonstration Population 4 (HIP Caretakers).** Expenditures for health care related costs for uninsured adults who are custodial parents and caretaker relatives of children eligible for Medicaid and the Children's Health Insurance Program (CHIP) with family income up to and including 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or Medicare, who do not have access to an employer-sponsored health plan, have been uninsured for 6 months, and whose health care expenditures do not exceed a $1 million lifetime maximum on benefits under the demonstration.

2. **Demonstration Population 5 (HIP Adults).** Expenditures for health care related costs for uninsured adults who are non-custodial parents or childless adults, ages 19 through 64 with family income up to and including 200 percent of the FPL, who are not otherwise eligible for Medicaid or Medicare, who do not have access to an employer-sponsored health plan, have been uninsured for 6 months, and whose health care expenditures do not exceed a $1 million lifetime maximum on benefits under the demonstration.

3. **Expenditures Related to MCO Enrollment and Disenrollment.** Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Indiana managed care plans which serve HIP members will be required to meet all requirements of section 1903(m) of the Act except the following:

   Section 1903(m)(2)(A)(vi) and (xi) insofar as they incorporate Federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) of the Act are inconsistent with the disenrollment rules contained in paragraph 31 of the Demonstration's Special Terms and Conditions, such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 60 days of enrollment in an MCO or before they make their first POWER account

contribution, whichever occurs first. Enrollees may disenroll from an MCO with cause at any time.

4. **Payments for Non-Risk Contractor**
   Payments to the HIP Indiana Comprehensive Health Insurance Association prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the State plan in accordance with the upper limits at 42 CFR 447.362. Payments shall not exceed Medicare reimbursement rates.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Population 4 and Demonstration Population 5 beginning January 1, 2008, through December 31, 2012.

Title XIX Requirements Not Applicable to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults)

1. Reasonable Promptness — **Section 1902(a)(3)**, **Section 1902(a)(8)**

To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER Account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER Account.

2. Methods of Administration: Transportation — **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana to not assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

3. Eligibility Section — **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER Account.

4. Amount, Duration, and Scope of Services — **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer benefits to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration, and scope of services offered to individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of $300,000.

5. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

6. Freedom of Choice **Section 1902(a)(23) insofar as it incorporates 42 CFR 438.52(a)**

To the extent necessary to enable Indiana to provide only one choice of plan for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are identified as having certain high-risk conditions.

7. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER Account.

8. Prepayment Review **Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana to not ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. Premiums **Section 1916(a)(1)**

To the extent necessary to enable Indiana to charge premiums for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. Dental and Vision Coverage for Certain HIP Caretakers and HIP Adults **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00237/5**

TITLE: **Healthy Indiana Plan**

AWARDEE: **Indiana Family and Social Services Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Indiana's Healthy Indiana Plan (HIP) section 1115(a) Medicaid Demonstration (hereinafter referred to as "Demonstration"). The parties to this agreement are the Indiana Family and Social Services Administration ("State") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2008, unless otherwise specified. This Demonstration is approved through December 31, 2012.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Hoosier Healthwise
VI. Healthy Indiana Plan
VII. General Reporting Requirements
VIII. General Financial Requirements
IX. Monitoring Budget Neutrality for the Demonstration
X. Evaluation of the Demonstration
XI. Schedule of State Deliverables during the Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

The HIP section 1115(a) demonstration provides authority for the State to operate two distinct health insurance products: the Hoosier Healthwise (HHW) Program for current Medicaid eligible persons, and the HIP for uninsured adults not currently eligible for Medicaid.

HIP offers the following coverage:

1) A basic commercial benefits package once annual medical costs exceed $1,100;
2) A Personal Wellness and Responsibility (POWER) Account valued at $1,100 per adult to pay for initial medical costs. The POWER Accounts provide incentives for participants

to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER Accounts depending on their income level; and

3) $500 in ―ifst dollar" preventive benefits at no cost to HIP members.

Medicaid Managed Care: Hoosier Healthwise and Medicaid Select

Indiana currently requires managed care enrollment for most Medicaid eligibles. Section 1931 children and adults are served under the Hoosier Healthwise program, while the aged, blind, and disabled are served under the Medicaid Select Program.

Indiana began the Hoosier Healthwise program in 1994, when it mandated managed care enrollment for all section 1931 children and adults through a waiver granted by the Secretary under the authority of section 1915(b) of the Social Security Act (the Act). By July 1997, the program was implemented statewide using a combination of managed care organizations (MCOs) and a Primary Care Case Management (PCCM) delivery system. Effective December 2005, all Hoosier Healthwise enrollees are served exclusively by MCOs.

Effective January 1, 2008, the authority for the Hoosier Healthwise program is provided solely through this demonstration.

The Medicaid Select program began in 2002, when Indiana began enrolling the aged, blind and disabled into managed care through a PCCM delivery system. Authority for this program continues to be provided under the authority of section 1915(b) of the Act. On October 1, 2007, an enhanced PCCM system called Indiana Care Select was phased in to provide care management services to the aged, blind, and disabled enrolled in Medicaid Select. All aspects of care delivery and financing of Medicaid Select and Indiana Care Select are separate and apart from this demonstration.

Healthy Indiana Plan (HIP)

The HIP provides a high-deductible health plan and an account styled like a health savings account called a POWER Account to uninsured adults including low-income custodial parents and caretaker relatives of Medicaid and Children's Health Insurance program (CHIP) children and uninsured non-custodial parents and childless adults. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through the high deductible health plans and POWER Accounts. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the health plan will provide coverage for medical services up to an annual maximum amount. Eligible individuals who have certain high-risk conditions will be enrolled in the Enhanced Services Plan (ESP), a separate care delivery mechanism managed by the Indiana Comprehensive Health Insurance Association (ICHIA), the State's high-risk pool.

Under this Demonstration, Indiana expects to achieve the following to promote the objectives of title XIX:

- Access: Ensure availability of necessary health services for Medicaid enrollees while offering health coverage to thousands of uninsured individuals;
- Prevention: Encourage individuals to stay healthy and seek preventive care;
- Personal Responsibility: Give individuals control of their health care decisions and incentivize positive health behaviors;
- Cost Transparency: Make individuals aware of the cost of health care services; and
- Quality: Encourage provision of quality medical services to all enrollees. Encourage quality, continuity, and appropriate medical care.

The following populations will participate in the Hoosier Healthwise (HHW) component of the Demonstration. The three populations derive their eligibility through the Medicaid State plan.

- **Demonstration Population 1: HHW Caretakers.** HHW Caretakers include parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the State plan and resources less than or equal to $1,000.
- **Demonstration Population 2: HHW Children.** HHW Children include all children eligible for Medicaid under the Medicaid State plan.
- **Demonstration Population 3: HHW Pregnant Women.** HHW Pregnant Women include pregnant women up to and including 200 percent of the Federal poverty level (FPL).

The following populations will participate in the HIP component of the Demonstration:

- **Demonstration Population 4: HIP Caretakers.** HIP Caretakers include uninsured custodial parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the State plan with resources in excess of $1,000; and, uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family income above the AFDC income limit specified in the State plan through 200 percent of the FPL (no resource limit).

- **Demonstration Population 5: HIP Adults.** HIP Adults include uninsured non-custodial parents and childless adults (ages 19 through 64) who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200 percent of the FPL (no resource limit).

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes related to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, unless specified

otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as not applicable, shall apply to the Demonstration.

3. **Compliance with the Deficit Reduction Act of 2005.** The foregoing requirement shall apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005 (DRA) signed into law on February 8, 2006, and applicable CMS regulations in the Code of Federal Regulations (CFR), including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the (the Act) and the cost-sharing limitations in section 1916 of the Act, unless specified otherwise in the STCs, waiver list, or expenditure authorities or listed as not applicable.

4. **Changes in Medicaid Law, Regulation, and Policy.** The State shall, within the time frames specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State shall adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration, as necessary, to comply with such change. The modified budget neutrality agreement would be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC.

    b. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

6. **State Plan Amendments.** The State shall not be required to submit title XIX State plan amendments for changes to Demonstration populations made eligible solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan is required, except as otherwise noted in these STCs.

7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements shall be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 8 below.

8. **Demonstration Amendment Process.** Requests to amend the Demonstration shall be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

   a. An explanation of the public process used by the State to reach a decision regarding the requested amendment, as referenced in paragraph 16 of these STCs.

   b. A data analysis that identifies the specific ―with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current total computable ―with waiver" and ―without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the ―with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment.

   c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation.

   d. A description of how the evaluation design shall be modified to incorporate the amendment provisions, if applicable.

9. **Extension of the Demonstration**. If the State intends to extend the Demonstration beyond the period of approval granted under section 1115(a), the requirements in section 1115(e) may apply. During the 6-month period ending 1 year before the date the Demonstration would otherwise expire, the chief executive officer of the State may submit to the Secretary of the Department of Health and Human Services a written request to extend the Demonstration for up to 3 years. If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted. Further, the Secretary shall take such steps as may be necessary to ensure that in the extension of the Demonstration budget neutrality is maintained. The timeframes for an extension under 1115(e) may not apply if the State has requested changes to the Demonstration. The State must also provide an interim evaluation report for the current extension period with the extension request, pursuant to paragraph 73.

10. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs

associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

11. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 10, during the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current Medicaid State plan shall not be permitted unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the waiver will not be renewed.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

14. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS shall promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

15. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

16. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e)(2)(A)(iii) of the American Recovery and Reinvestment Act (ARRA) of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 7, are proposed by the State. In States with Federally recognized Indian tribes, Indiana health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this Demonstration.

17. **Compliance with Managed Care Regulations.** The State shall comply with the managed care regulations at 42 CFR section 438 et seq., except as expressly waived or expressly identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6.

18. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

IV. ELIGIBILITY

19. **Eligibility.** The HIP demonstration includes two distinct components.

    The HHW program provides Medicaid State Plan benefits through comprehensive MCOs to children, pregnant women and caretaker adults eligible under the State plan as described below. The HIP provides a high-deductible health plan and a Personal Wellness and Responsibility (POWER) Account through comprehensive managed care organizations to uninsured adults with and without children who have specified income and assets.

    The mandatory and optional Medicaid State plan populations described below in Table 1 derive their eligibility through the Medicaid State plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived. State plan eligibles are included in the Demonstration to generate savings for covering expansion populations and to mandate enrollment in managed care by waiving the freedom of choice of provider requirement.

    Groups which are made Demonstration eligible by virtue of the expenditure authorities expressly granted in this Demonstration as described below in Table 2 are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as specified otherwise in the STCs and expenditure authorities or otherwise listed as not applicable.

    The eligibility criteria for the HIP demonstration are outlined below. These tables are presented for information purposes and do not change the State plan requirements or otherwise establish policy.

Hoosier Healthwise Component of the Demonstration

The populations described in Table 1 are in the Medicaid State plan and included in the Demonstration to generate savings for covering expansion populations, to mandate enrollment in managed care, and waive other requirements as specified in the Waiver List. None of the Hoosier Healthwise populations participate in the HIP component of the Demonstration. Therefore, none of the Hoosier Healthwise populations have POWER Accounts.

Table 1: Hoosier Healthwise Program

State Plan Mandatory and Optional Groups		
Description	**FPL Level and/or other qualifying criteria**	**Demonstration Eligibility Group**
Pregnant women	0% FPL through 200% FPL; no resource limit	HHW Pregnant Women
Qualified Pregnant Women	Pregnant women up to the AFDC income limit for the particular family size as indicated in the State plan; resource limit of $1,000	HHW Caretakers
Children under age 1	0% FPL through 200% FPL; no resource limit	HHW Children
Newborns born to & living with a woman who was eligible and received Medicaid on the date of the child's birth	Eligible for 1 year as long as mother is eligible for Medicaid or would be if pregnant and the child remains in the same household as mother.	HHW Children
Children 1 through 5	0% FPL through 133% FPL; no resource limit	HHW Children
Children 6 through 18	0% FPL through 100% FPL; no resource limit	HHW Children
Blind and Disabled children under age 18 receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the State plan FPL; resource limit of $1,000	HHW Children
Custodial parents and caretaker relatives of children eligible for Medicaid	Income up to and including the AFDC income limit for the particular family size as indicated in the State plan; resource limit of $1,000	HHW Caretakers
Blind and Disabled adults 18 years old and older receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the State plan; resource limit of $1,000	HHW Caretakers

Healthy Indiana Plan Component of the Demonstration

The populations described in Table 2 are in the HIP component of the Demonstration. All of the populations described below will be required to make monthly contributions to their POWER Accounts.

Table 2: Healthy Indiana Plan (HIP) Program

Demonstration Eligible Groups		
Description	**FPL Level and/or other qualifying criteria**	**Demonstration Eligibility Group**
Custodial parents and caretaker relatives currently excluded from the Medicaid State plan who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income up to the AFDC income limit for the particular family size as indicated in the State Plan with resources in excess of $1,000	HIP Caretakers
Custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income above the AFDC income limit for the particular family size as indicated in the State Plan and up to and including 200% FPL; no resource limit.	HIP Caretakers
Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers, who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	0% FPL through 200% FPL; no resource limit. At no point in time may the number of individuals exceed 36,500.	HIP Adults

20. **Eligibility Exclusions.** Notwithstanding the eligibility criteria in paragraph 19, the following persons are excluded from the Demonstration.

    Hoosier Healthwise Program
    - Persons eligible for Medicaid exclusively through categories other than those listed above in Table 2.
    - Individuals eligible for Medicare.

    Healthy Indiana Plan
    - Individuals eligible for Medicare or Medicaid under the State Plan.
    - Individuals who have access to an employer-sponsored health plan.
    - Individuals who are currently enrolled in a health insurance program.

21. **Income of HIP Caretakers.** The State will disregard the income of individuals seeking eligibility as HIP Caretakers in the amount of the difference between the standard specified in Supplement 1 to Attachment 2.6A Page 1 of the Medicaid State plan and 200 percent of the FPL for the family size involved. The State will disregard the resources of individuals seeking eligibility as HIP Caretakers.

    The State may submit an amendment to the Demonstration to specify different income and/or asset disregards for new HIP Caretaker applicants than for those already determined eligible following procedures described in paragraph 8.

22. **Enrollment Cap for HIP Adults.** At no point in time may the number of individuals enrolled as HIP Adults exceed 36,500.

V. HOOSIER HEALTHWISE

23. **Benefits.** Benefits offered to HHW enrollees are outlined in the State plan. HHW enrollees may also receive chronic disease management services. All benefits, with the exception of pharmacy, are delivered through a managed care delivery system. Beginning January 1, 2010, pharmaceutical services are expected to be provided through a fee-for-service delivery system.

24. **Enrollment.** The State will continue to follow applicable Federal law and regulations for determining eligibility for Medicaid and for enrolling those deemed eligible into MCOs, as well as policies and procedures that are described in the Medicaid State plan. The State may require members of the Medicaid eligibility groups described in paragraph 19 to enroll with an MCO as a condition for receiving medical assistance. The State may allow MCOs to assist enrollees in completing their applications for redeterminations; however, the State will be responsible for making the redetermination decision.

25. **Cost Sharing.** Any cost sharing requirements for HHW enrollees are stipulated in the Medicaid State plan.

VI. HEALTHY INDIANA PLAN (HIP)

26. **General Description.** The HIP provides a high-deductible health plan and an account styled like a health savings account called a Personal Wellness and Responsibility (POWER) Account to uninsured adults including low-income parents and caretaker relatives of Medicaid and CHIP eligible children and uninsured childless adults. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through one of two delivery systems described below. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the HIP MCO or Enhanced Services Plan (described below) will provide coverage for medical services up to an annual maximum amount.

The State provides benefits under the HIP using one of two delivery systems. For those enrollees who have an identified high-risk condition, benefits are rendered through the Enhanced Services Plan, a prepaid inpatient health plan (PIHP), operated by ICHIA, the same entity that manages the State's high risk pool. All other enrollees receive coverage through MCOs under contract to the State. The MCOs and ESP are subject to the Federal laws and regulations as specified in 42 CFR Part 438.

In all cases, the enrollee is responsible for making contributions to a POWER Account.

Eligibility Determination, Enrollment, and Disenrollment

27. **Enrollment into HIP.** Individuals may apply for HIP in one of two ways. Applicants may apply at Designated Enrollment Centers or directly at the Division of Family Resources (DFR) offices.

    a. **Application through Designated Enrollment Centers (DEC).** Individuals may complete an application through designated enrollment centers (such as hospitals, schools, community organizations, health clinics, etc.). The State will ensure that the DECs, as outstationed eligibility centers, comply with the regulations set forth at 42 CFR 435.904. The applicant may make an MCO selection at this time. As part of the application, a high-risk health questionnaire will also be required.

    The DECs will forward complete applications, including all supporting documentation, to DFR within 35 days of the application's signature date, either online or via U.S. mail. DFR will make a final eligibility determination within 45 days of the signed application date. This 45-day period is inclusive of the 35 days the DEC has to forward the completed application to DFR.

    b. **Application through the Division of Family Resources (DFR).** The DFR will explain the HIP program and take an enrollee's application for the program. Individuals will also be able to apply for HIP online, over the phone, and by mail. The applicant may make an MCO selection at the time they apply. As part of the application, a high-risk health questionnaire will also be required.

    The applicant's application form will be checked for completeness through an automated process. If the application is not complete, DFR will contact the applicant to obtain the missing information. DFR will make a final eligibility determination within 45 days of the signed application date.

28. **MCO Information and Selection.** The State will contract with an enrollment broker to assist interested applicants with their MCO selection so they can make an informed decision. The enrollment broker will provide the applicant with appropriate counseling on the full spectrum of available MCO choices and will address any questions the applicant may have. Once an MCO has been selected, the enrollee is required to remain in that MCO for 12 months (coverage term), with limited exceptions specified in paragraph 31.

Individual family members may select different MCOs. If no family member receives coverage through ESP and no eligible family member has selected a plan, all eligible family members will be auto-assigned to the same MCO. If one of the family members receives coverage through ESP as described in paragraph 29, and no family member has selected a plan, all non-ESP family members will be auto-assigned to the same MCO.

29. **The Enhanced Services Plan for Individuals with High Risk Conditions.**

a. If the high-risk health questionnaire completed at the time of application indicates that the applicant has one of the ESP-eligible conditions, the applicant will be enrolled by the State in the ESP. The State will determine which conditions are eligible for the ESP program on an annual basis and will indentify these conditions in the MCO contracts. Some examples of conditions that are eligible for the ESP program include cancer, past recipient of organ and/or tissue transplants or awaiting an organ and/or tissue transplant, HIV/AIDS, aplastic anemia, or hemophilia. . ESP is a PIHP that is managed by ICHIA, the organization that also manages the State's high risk pool. Persons enrolled in ESP will have access to the provider network maintained by ICHIA, and will be free to receive care from any ICHIA affiliated provider. The ESP specializes in managing populations with high-risk medical conditions. ESP members will receive disease and case-management services that will assist them in managing their health conditions.

b. Demonstration eligibles assigned to ESP will be required to make monthly POWER Account contributions, with amounts determined on the same basis as for HIP MCO enrollees, following paragraphs 40 and 41. Indiana may elect either option (i) or (ii) below with respect to implementation of POWER Accounts for persons assigned to ESP. The State must include a report on which option it is currently using, and any plans to change the option, in each Quarterly Progress Report (as required under paragraph 56).

i. Indiana may elect to make State contributions to ESP enrollees' POWER Accounts, as described in paragraph 42. The State will require ESP to manage their enrollees' POWER Accounts, in conformity with paragraphs 43 through 51. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 34, once their annual deductible has been reached, as well as disease management services provided by ESP. The State will reimburse ESP for the cost of all services provided to an enrollee in excess of those defrayed through the enrollee's POWER Account.

ii. Indiana may elect not to make State POWER Account contributions to ESP enrollees' POWER Accounts. In this case, ESP must collect the required monthly POWER Account contributions and will use these monies to defray the cost of services provided to ESP enrollees within the coverage term. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 34, as well as disease management services provided by ESP. The State will reimburse ESP for the cost of services provided to an enrollee beyond those defrayed by the enrollee's POWER Account contributions. If, during the course of a coverage term, an individual's

medical claims do not exceed $1,100 for the year, the enrollee's required contribution for the new year will be based on the POWER Account carry-forward procedures, as described in paragraph 46(c), and calculated as if the State had made a full POWER Account contribution as stipulated in paragraph 42(a).

c. Demonstration eligibles assigned to ESP will not be considered to be enrolled in ICHIA, the State's high risk pool; ESP will provide only administrative services and access to the ICHIA provider network. ESP will also provide disease management services.

d. If the high-risk condition was not disclosed on the high-risk health questionnaire or is not identified on the application, but is on the list ESP-eligible conditions, the MCO may refer an individual to the ESP Plan. The requirements governing the MCO's referral are outlined in the MCO contracts. In general, the MCO's referral must be supported by the documentation required by the State's referral criteria such as the appropriate physical examination, initial claims data, and/or physician questionnaire. In general, if the State does not receive the MCO's notification and/or request to transfer the enrollee to ESP within 180 days (or the time period denoted in the MCO contract), the enrollee will remain in the MCO for the rest of the coverage term. At the end of the coverage term, the MCO will have another opportunity to use prior claims data, a physician exam, or a physician questionnaire as determined by the State's referral criteria to transfer the enrollee to ESP. The MCOs will be subject to an audit of their transfers of HIP members to the ESP. The specifics of the audits and the penalties associated with the audits are outlined in the MCO contracts.

e. At the time of redetermination, the State may transfer an enrollee from ESP to an MCO if the State or its designee determines that the enrollee does not have an ESP-eligible condition. The requirements governing how an ESP member could be transferred to an MCO are outlined in the MCO and ESP contracts. In general, if a member is not found to have an ESP-eligible condition, the member will be sent a notice informing the member that he or she will be transferring from the ESP to their MCO choice once the redetermination is completed. The notice will inform the member that the member may make a new plan choice.

   The State will develop a process through which a HIP member may appeal the State's decision to move the member out of an MCO to ESP or out of ESP to an MCO. The State shall include a description of this process in the first Annual Report required in paragraph 57.

30. **Auto Assignment to an MCO**. Any applicant who does not make an MCO selection at the time of application may be auto-assigned to a HIP MCO by the State. Auto-assignment may occur after the date in which the State determined their eligibility, or 14 days after the application's signature date, whichever is later.

    Auto-assignment will be done on a rotating basis to assure that applicants are assigned evenly among MCOs. The State may consider assignment to the lowest cost MCO, or to the MCOs

that demonstrate strong health outcomes and quality health care services. Enrollees will be advised promptly of the auto-assignment and their right to change MCOs before the first POWER Account contribution is made.

31. **Enrollee's Right to Change MCOs.** For the first year of the Demonstration, HIP members may have only one choice of an MCO. By Demonstration Year 2, the State must offer at least two choices of MCOs. The procedures outlined below will take effect as soon as a second HIP MCO begins accepting clients, but no later than January 1, 2009.

    a. At the beginning of their first coverage year, an enrollee may change HIP MCOs without cause within 60 days after initially choosing or being auto-assigned to a HIP MCO, or the date their HIP MCO received their first POWER Account contribution, whichever comes first.

       The State shall notify HIP members 90 days before the end of their coverage term that they must apply for continued coverage. The State shall also notify HIP members that they may change plans without cause at the time they submit their application for a second or subsequent coverage term. Members may seek assistance from the enrollment broker in choosing an MCO.

    b. "Cause" is defined as "receiving poor quality care coverage," which includes, but is not limited to, the following:
       i. Failure of the Insurer to provide covered services;
       ii. Failure of the Insurer to comply with established standards of medical care administration;
       iii. Significant language or cultural barriers.
       iv. Corrective Action levied against the Insurer by the Family and Social Services Administration (FSSA); or
       v. Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

    c. The enrollee must submit his or her request for change to the enrollment broker either orally or in writing. The enrollment broker will assure that the enrollee has sought redress through the MCO's grievance system before referring the request to the State for making a determination regarding the change request. The enrollee shall still have access to the State's normal grievance and appeals process required under the managed care regulations.

    d. If the State fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the request for change will be considered approved and the enrollee will be transferred into the new MCO.

    e. If an enrollee is transferred from the MCO, the MCO must disable the enrollee's POWER Account card immediately, and return the remaining balance of the individual's POWER Account balance to the State within 30 days of the last date of participation with the MCO. The State will then provide the entire POWER Account

balance to the new MCO with the information needed to properly track the individual's contribution.

f. The State will ensure that all transferring individuals receive coverage from their new MCO promptly, without any interruption in coverage.

32. **Redetermination of Eligibility**. Redetermination of eligibility for HIP will occur at least once every 12 months. An enrollee may request a redetermination of eligibility for HIP due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the State must perform such redeterminations upon request. Requests for redetermination based on changes in income will be subject to a once a year qualifying event. A ―qualifying event" is defined as a job loss or other event resulting in a change in income. Each redetermination must include a reassessment of the individual's eligibility for Medicaid, and may result in a reduction of the enrollee's required POWER Account contribution. The State may consider allowing more than one ―qualifying event" a year on a case-by-case basis, if the HIP member experiences a job loss or other change in income that results in undue hardship. The enrollee's MCO may assist the enrollee in completing the steps necessary to remain eligible for HIP.

33. **Disenrollment from HIP unrelated to POWER Accounts.** The State may disenroll an enrollee from HIP for any of the following reasons:

    a. The enrollee is determined ineligible for HIP at redetermination;

    b. The enrollee obtains access to employer-sponsored coverage;

    c. The enrollee becomes covered under another health insurance policy or FSSA program; or

    d. The enrollee becomes pregnant. Upon pregnancy, the enrollee will become eligible for Hoosier Healthwise, and will be enrolled in that program.

    e. Should a participant be disenrolled from HIP for any of the reasons listed above, the HIP MCO must return any remaining POWER Account balances to the participant or the State as described in paragraph 48.

<u>Benefits</u>

34. **HIP Covered Benefits.** HIP covers physical, behavioral health and pharmacy services as specified below. All benefits are limited by medical necessity as defined by the State. This list of benefits specifies the minimum set of benefits available to HIP members.

Table 3: Healthy Indiana Plan Benefits

Benefit	Limits
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service
Skilled Nursing Facility	Subject to a 60-day maximum
Outpatient Facility	
Surgery	
Emergency Room	Co-payment for services determined to be non-emergency as specified in Section VI, paragraph 38(b)
Urgent Care	
Physical/Occupational/ Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Pharmacy and Blood	
Cardiovascular	
Professional Services	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient/ ER Visits	
Office Visits/ Consults	
Preventive Services	At least $500 annual first dollar coverage
Physical/Occupational/Speech Therapy	25-visit annual maximum for each therapy
Cardiovascular	
Radiology/Pathology	
Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness
Ancillary Services	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available.
Home Health (including hospice)/ Home IV Therapy	Excludes custodial care. Includes case management.
Ambulance	Emergency ambulance transportation only, subject to the prudent layperson's standard.
Durable Medical Equipment/ Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).

Benefit	Limits
Lead Screening Services	Ages 19 and 20 only
Hearing Aides	Ages 19 and 20 only
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services	Subject to the HIP benefit coverage limits
Disease Management Services	

35. **Preventive Benefits.**

    a. Enrollees will have an annual budget of at least $500 for ―first dollar coverage" to pay for preventive services. Enrollees may not be required to pay any cost sharing for the first $500 of preventive services in any coverage year. The first $500 in preventive care service will not count against the $1,100 annual deductible and will not be accessed using the enrollee's POWER Account card. Preventive services in excess of the ―first dollar coverage," are covered, but are subject to the deductible.

    b. For coverage terms beginning the first year of the demonstration, each enrollee is required to receive an annual physical by the end of their 12-month eligibility period. For subsequent years of the demonstration, each enrollee will be required to access the appropriate preventive services (defined as care that is provided to an individual to prevent disease, diagnose disease, or promote good health) for their specific age and gender as described in paragraph 35(c) below. These requirements are for purposes of the carry-forward of POWER Account funds described in paragraph 46(c).

    c. As part of the first Quarterly Progress Report (as required under paragraph 56), the State will submit a list of the services (including services codes) that are considered to be preventive services that can be provided from the $500 of ―first dollar coverage," and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds described in paragraph 46(c). Any changes to these must be reported by the State in a subsequent Quarterly Progress Report. The current preventive services requirements to receive full carry-forward of POWER Account funds must be posted promptly to FSSA's public Web site.

36. **Changes to Benefits.** Changes to HIP benefits shall be made by amendment to the Demonstration, in accordance with Section III, paragraph 8.

37. **Annual and Lifetime Benefit Limits.** The benefits available under HIP are limited to $300,000 annually and $1 million over a lifetime.

    a. If during a coverage term, an enrollee exceeds the annual benefit limit of $300,000, the enrollee will remain enrolled in the MCO or ESP and must continue to make POWER Account contributions; however, the enrollee will not have access to

covered services. After redetermination and at the beginning of a new coverage term, the enrollee will have reinstated access to covered services.

b. If an enrollee exceeds the lifetime benefit limit of $1 million, the enrollee will be disenrolled from HIP following the procedures specified in paragraph 48(c). If enrollees exceed $200,000 in benefits in a year or $900,000 in benefits in a lifetime, they must be informed that they may apply for Medicaid, Medicaid for Employees with Disabilities (M.E.D. Works), and/or ICHIA, the State's high risk pool. Notices must be provided to ensure the enrollee has a reasonable time to provide the necessary documentation.

Cost Sharing

38. **Allowable Cost Sharing**

a. HIP enrollees may not be subject to any cost sharing requirements (as defined in section 1916A(a)(2)(B) of the Act) as a condition for receiving services, other than what is described in (b) below. Neither the required monthly POWER Account contributions discussed in paragraph 40, nor payments made from the POWER Account to defray the cost of services prior to the deductible being reached, are considered cost sharing for this purpose.

b. HIP enrollees may be charged co-payments for non-emergency use of a hospital emergency department, subject to the following conditions.

i. The maximum amounts that can be charged to HIP enrollees are as follows:

Population	Co-Payment Amount
HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL	$3 per visit
HIP Caretakers Above 100 % through 150% FPL	$6 per visit
HIP Caretakers Above 150 % through 200% FPL	Lower of 20 percent of the cost of the services provided during the visit, or $25
HIP Adults	$25 per visit

ii. The conditions stated in section 1916A(e)(1) of the Act and in the August 15, 2007, State Medicaid Directors Letter (SMDL) #07-010 must be met.
iii. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.
iv. Assuming the individual actually has an available and accessible alternate non-emergency services provider and a determination has been made that the individual

does not have an emergency medical condition, the hospital must inform the individual before providing non-emergency services that:

- The hospital may require payment of the above-named cost sharing before the service can be provided.
- The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible.
- An alternate provider can provide the services without the imposition of the State-specified higher cost sharing for the inappropriate use of the ER.
- The hospital provides a referral to coordinate scheduling of this treatment.

v. The co-payment for HIP Caretakers must be refunded if the person is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Act, or if the person is admitted to the hospital on the same day as the visit. The co-payment for HIP Adults need not be refunded.

c. For families that include HIP Caretakers, the total aggregate amount of POWER Account contributions, Medicaid and HIP cost sharing, and CHIP premiums and cost sharing may not exceed 5 percent of the family income of the family involved. Family income will be determined under the methodology applicable to the group under the State Medicaid plan. The State must develop a process for ensuring that families do not exceed the 5 percent cost sharing limit, and must include a description of this process in the first Annual Report required in paragraph 57.

POWER Accounts

39. **General Description.** The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and will, at a minimum, be funded with State, Federal, and enrollee contributions. Employers may contribute as well, with some restrictions. POWER Accounts will be funded with post-tax dollars and are not considered HSAs or other health spending accounts (e.g., Flexible Spending Accounts, Health Reimbursement Accounts, etc.) under Federal law. Therefore, the POWER Accounts are not subject to regulation under the Internal Revenue Code, 26 U.S.C.A., as such. Instead, the functioning of the POWER Accounts shall be governed by these STCs.

    POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. Enrollees will be informed that responsible use of POWER Account funds, as well as utilization of recommended preventive care services, can lead to a reduced financial burden in the subsequent years. If enrollees are aware that prudent management of their health care expenditures can leave them with available funds at the end of the year—and that these funds can be used to lower the following year's contribution—enrollees will be encouraged to make value- and cost-conscious decisions.

    Enrollees will make the same POWER Account contribution regardless of the delivery system under which they receive benefits. The amount of annual POWER Account

contributions is based on family size and income. Family income will be determined under the methodology applicable to the group under the State Medicaid plan. The enrollee's coverage will begin on the first of the month after his or her first POWER Account contribution is received and processed.

Therefore, individuals eligible for HIP are deemed –conditionally eligible" until they make their first POWER Account contribution. Eligibility does not become final until the individual has made their first POWER Account contribution and, if the payment is made by check, the check clears to the MCO or ESP.

40. **Required Participation in a POWER Account.** HIP enrollees are required to help fund the $1,100 deductible by contributing to a POWER Account. Contributions will be determined on a sliding scale based on the enrollee's income, will not exceed 5 percent of an enrollee's gross annual family income, and will be reduced by other payments made to CHIP, Medicaid, or Hoosier Healthwise.

    a. The sliding scale for POWER Account contributions is as follows:

Table 4 – POWER Account Contributions

Annual Household Income	Maximum POWER Account Contribution
All enrollees at or below 100 percent FPL	No more than 2 percent of income
All enrollees above 100 through 125 percent FPL	No more than 3 percent of income
All enrollees above 125 through 150 percent FPL	No more than 4 percent of income
HIP Caretakers above 150 through 200 percent FPL	No more than 4.5 percent of income
HIP Adults above 150 through 200 percent FPL	No more than 5 percent of income

    b. The State will develop an algorithm to determine the amount of an enrollee's annual required contribution and will notify the MCO and ESP of this amount. The MCO and ESP must bill for, and collect, the required enrollee contribution.

    c. Enrollees must be given the opportunity to pay their required contribution in equal monthly installments.

41. **Enrollee POWER Account Contributions.** The State will notify new enrollees of POWER Account contribution requirements at the same time the State informs new enrollees that they have been found –conditionally eligible."

    a. **Initial Enrollee Contribution.** The first installment will be due 60 days after the enrollee is enrolled into an MCO or ESP, and may not exceed one-twelfth (1/12) of the enrollee's total required annual POWER Account contribution. HIP coverage will not begin until the first day of the coverage month after the first POWER Account contribution installment is received, or, if payment is made by check, the check clears. The MCO or ESP must notify the State within 5 to 30 days after an enrollee's first POWER Account contribution installment has been received.

b. **Ongoing Monthly POWER Account Contributions.** In families with two enrolled individuals, each enrollee will have their own POWER Account. However, the total of both enrollees' POWER Account contributions cannot exceed the total POWER Account contribution that applies to the family's annual household income as specified in paragraph 40(a).

c. **Recalculation of Enrollee POWER Account Contribution Amount**. At the end of each coverage term and after the enrollee has been determined eligible for another coverage term, the enrollee's POWER Account contribution may need to be recalculated for the new coverage term, based on changes in the enrollee's annual household income identified at the time of redetermination.

   The State will notify the MCO or ESP of the enrollee's POWER Account contribution for the new coverage term, and within 60 days, the MCO or ESP will:

   i. Reduce the enrollee's POWER Account contribution for the new coverage term by the amount of the enrollee's POWER Account balance that was carried forward as calculated in paragraph 46(c);
   ii. Notify the enrollee of this roll-over amount, as well as the new amount to be billed to the enrollee in equal monthly installments in the new coverage term; and
   iii. Reconcile any overpayments or underpayments made by the enrollee as a result of the overlapping timeframes of monthly payments and recalculation of new contribution amounts for the new coverage term.

42. **State POWER Account Contributions.**

   a. The State will fund any gap between a non-ESP enrollee's annual required POWER Account contribution and the $1,100 deductible. The State will make its <u>entire</u> contribution to the POWER Account promptly after receiving notice from the MCO that the enrollee's first POWER Account contribution has been received and processed.

   b. The State may choose whether or not to fund the gap between an ESP enrollee's annual required POWER Account contribution and the $1,100 deductible, following requirements addressed in paragraph 29.

43. **"Up -Front" POWER Account Contribution by MCO or ESP.**

   a. In the case where a covered service may exceed the member's current POWER Account balance, the MCO or ESP must reimburse the provider for the balance according to its normal claims processing procedures. The MCO or ESP can recover the funds it paid on the member's behalf with future POWER Account contributions paid by the member.

   b. If an enrollee is terminated under the provisions in paragraphs 47 and 49 before the full annual POWER Account contribution is paid to the MCO or ESP, the MCO or ESP will levy the enrollee's account and notify the State of the enrollee's debt.

c. The MCO or ESP may attempt to collect the unpaid POWER Account contributions from the enrollee, including reporting the debt to credit reporting agencies. However, the MCO or ESP may not "sell" the debt for collection by a third-party.

d. If the enrollee should reapply for HIP, after the mandatory 12-month waiting period specified in paragraphs 46 and 48, the enrollee must pay the prior POWER Account debt as well as the first month's contribution before services can begin.

44. **Employer Contributions**. Employers are permitted and encouraged to contribute to their employees' POWER Accounts. An employer's contribution must be used to offset the employee's required contribution only—not the State's.

45. **POWER Account Card.** The MCO or ESP must issue a card to each enrollee promptly after processing the enrollee's first POWER Account contribution, within thirty (30) days. This card may have all POWER Account contributions loaded onto it.

    a. An electronic account update will be e-mailed to the enrollee by the MCO or ESP each time a contribution is credited to the enrollee's POWER Account in order to reflect the new balance.

    b. The card may be used by enrollees only to pay for covered services performed by network providers.

    c. For covered services provided out-of-network, if the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's card, the MCO or ESP will reimburse the out-of-network provider with funds from the enrollee's POWER Account. ESP and the MCOs may also reimburse in network providers with funds from the enrollee's POWER Account if the network providers lack the capacity to conduct the transaction using the enrollee's card.

    d. The MCOs and ESP are required to have an internal system of safeguards for the cards and to manage the POWER Accounts. The State will actively monitor plans and their management of the POWER Accounts either through a separate annual audit or will require the plans to fund annual independent audits.

46. **Use of POWER Account Funds.** Each enrollee will be responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the enrollee to pay for the MCO's covered services, including any enhanced services the MCO may choose to offer.

    a. **Out of Network Providers.** In spending POWER Account funds, enrollees will be permitted to pay for the following covered services, even if obtained through out-of-network providers:

i. Family planning services;

ii. Emergency medical services, subject to the prudent layperson standard of an "emergency medical condition," as specified in 42 CFR 438.114;

iii. Medically necessary covered services, if the MCO's network is unable to provide the service within a 30-mile radius for primary care and a 60-mile radius for specialty care of the enrollee's residence; and

iv. Nurse practitioner services.

b. **Payment for Out of Network Providers.** For the out-of-network services specified in subparagraph (a), the MCO must coordinate with the out-of-network provider to ensure that the cost to the enrollee is no greater than it would be if the services were provided in-network. If the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's POWER card, the provider must be instructed to bill the MCO and the MCO must reimburse the out-of-network provider with funds from the enrollee's POWER Account.

c. **Carry-Forward and Use of Excess Funds.** At the end of a 12-month coverage term, there may be funds remaining in a enrollee's POWER Account. Some or all of the funds remaining in an enrollee's POWER Account may be carried forward to the next coverage term to reduce the enrollee's required POWER Account contribution in that coverage term. The amount of leftover funds available to be carried forward will depend on several factors outlined below.

i. If the enrollee has obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, the entire remaining POWER Account balance, including monies contributed by the State, will be carried forward. The enrollee's required contribution for the new year will be the amount determined using the State's algorithm (paragraph 40(b)), reduced by the amount carried forward. If the amount carried forward is greater than the amount determined using the State's algorithm, the required contribution for the new coverage year is $0. For non-ESP enrollees, the State must then contribute to the POWER Account an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and $1,100.

ii. If the enrollee has not obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, only the pro rata share of the enrollee's portion of the POWER Account balance may be carried forward. The pro rata share of the enrollee's portion equals the amount the enrollee's required contribution for the expiring coverage term, plus any enrollee balances rolled over from previous coverage terms, multiplied by the unspent percentage of the POWER Account from the expiring term. The State's portion of the unspent POWER Account balance, calculated similarly to the enrollee's portion

of the unspent POWER Account balance, must be returned by the HIP MCO to the State. The enrollee's POWER Account contribution for the next coverage term is the amount determined using the State's algorithm (paragraph 40(b)), minus the amount carried forward as calculated above. The State must contribute an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and $1,100. The State may collapse the recovery of the State share of the POWER Account balance and its contribution for the next coverage term into a single, net transaction.

iii. If the amount of funds available to be carried is in excess of the enrollee's required POWER Account contribution for the next coverage term, the excess amount will be credited to the State to reduce the State's contribution in the next coverage term. This shall occur regardless of whether or not the enrollee obtained his or her recommended preventive care services.

iv. The HIP MCOs and ESP must develop and maintain accounting systems capable of tracking POWER Account balances and sub-balances according to whether they were initially contributed by the enrollee or the State. POWER Account balances must maintain their identity as enrollee or State contributions throughout the process.

47. **Non-Payment of Monthly POWER Account Contribution.** If an enrollee does not make a required monthly contribution within 60 days of its due date, the enrollee will be terminated from participation in HIP and disenrolled from the MCO or ESP. The enrollee will also forfeit 25 percent of the enrollee's pro rata share of funds remaining in the POWER account.

a. Before terminating the enrollee, the MCO or ESP must provide at least one written notice advising the enrollee of the delinquent payment, and the date by which the contribution must be paid to prevent disenrollment, as well as notice of the enrollee's appeal rights. The notice must be sent to the enrollee on or before the seventh day of delinquency and must state that the enrollee will be disenrolled from the MCO or ESP and terminated from participation in HIP if payment is not received prior to the date specified in the notice. The notice must explain that if the enrollee is terminated from participation in HIP, the enrollee will not be able to reapply for HIP coverage for a period of at least 12 months.

b. The MCO or ESP is required to refund the enrollee's pro rata portion of the POWER Account, which must be distributed to the enrollee no later than sixty (60) days after the last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as follows:

i. Calculate the total enrollee contribution to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms (E^T);

ii. Calculate the amount actually contributed by the enrollee to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms (E^A);

iii. Calculate the percentage of the POWER Account expended during the coverage term, which will equal the total dollar amount expended, divided by $1,100 (u);

iv. Multiply the result in (iii) by the result in (i), and subtract from the result in (ii) ($R = E^A - u*E^T$).

v. If the result in (iv) is positive, the MCO or ESP must return 75 percent of this amount to the enrollee and 25 percent of this amount to the State.

vi. If the result in (iv) is negative, the result is the amount that the enrollee owes to the MCO or ESP as described in paragraphs 43(b) through 43(d).

vii. The MCO or ESP must return to the State all unexpended State POWER Account contributions, including amounts carried forward from prior coverage terms.

48. **Loss of Eligibility for HIP and POWER Account Contributions.** If an enrollee becomes ineligible for HIP, either at redetermination or at another time, the MCO or ESP must refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as in paragraph 47(b), except that in step (v), 100 percent of the result must be returned to the enrollee.

49. **Failure to Redetermine Eligibility and POWER Account Contributions.** If an enrollee fails to complete all necessary steps to maintain eligibility for HIP at the end of a coverage term, the enrollee will not be permitted to reapply for HIP for a period of at least 12 months.

    The MCO or ESP will be required to refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO. The amount payable to the enrollee shall be determined using the calculations specified in paragraphs 47 and 48. Unspent State POWER Account contributions must be returned to the State.

50. **POWER Account Balance Transfers.** If an enrollee transfers to a new MCO or ESP, the enrollee's POWER Account balance will be transferred to the State within thirty (30) days from the date the MCO or ESP was notified by the State.

    For a transfer at the end of a coverage term, the current MCO or ESP remains responsible for determining the amount of the enrollee's POWER Account that may be carried over, and forwarding that amount to the State. The State will forward the balance to the new MCO or ESP.

51. **POWER Account Reporting to State.** Each MCO and ESP must submit a report to the State each month that provides the following for each terminated or ineligible enrollee:

a. Demographic information on the enrollee;

b. The balance remaining in the enrollee's POWER account;

c. The amount paid to the enrollee as required under paragraphs 46 through 49; and

d. The amount to be returned to the State.

VII. GENERAL REPORTING REQUIREMENTS

52. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX set forth in these STCs.

53. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The State must submit any corrected budget and/or allotment neutrality data upon request.

54. **Compliance With Managed Care Reporting Requirements.** The State shall comply with all managed care reporting regulations at 42 CFR Part 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

55. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

56. **Quarterly Progress Reports:** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;

c. Action plans for addressing any policy, administrative, or budget issues identified;

d. Quarterly enrollment reports for Demonstration eligibles that include the member months for each Demonstration population, as required to evaluate compliance with the budget neutrality agreement, and as specified in Section VIII, paragraph 61; and other statistical reports listed in Attachment A; and

e. Evaluation activities and interim findings including the number of individuals who are within $100,000 of reaching the annual or lifetime benefit limit. The State shall report on its efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.

f. A report on which option the State is currently using and any plans to change the option regarding State contributions to ESP enrollees' POWER Accounts as outlined in paragraph 29(b).

g. A list of services (including service codes) that are considered to be preventive services that can be provided from the $500 of "first dollar coverage," and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds as outlined in paragraph 35(c).

57. **Annual Report.**

a. The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration.

b. In addition, the State shall include information on the following in its draft annual report:

   i. The level of preventive services compliance, including a summary of member compliance and non-compliance with Office of Medicaid Policy and Planning (OMPP) recommended preventive services.
   ii. The number of HIP Caretakers and HIP Adults who are within $100,000 of exceeding the annual and or lifetime benefit limit and the State's efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.
   iii. The progress of Indiana's care management program for the Aged, Blind, and Disabled (ABD) population and the feasibility of moving part or all of the ABD population into managed care.
   iv. Any strategies the State is examining to reduce the uninsurance rate in the State, such as restructuring the Small Group Reinsurance Pool to make it more attractive to small groups.

v. Incentive programs developed by HIP MCOs for providers and HIP members. Potential areas include emergency room utilization, access to care, asthma, obesity, preventive service utilization, and smoking cessation.
vi. A description of how health information technology (HIT) is progressing in the State and how the Demonstration has assisted in progressing HIT, including any HIT and data sharing initiatives that are developed or implemented by HIP MCOs to improve quality, efficiency, and safety of health care delivery in Indiana.
vii. A description of the process through which a HIP member may appeal the State's decision to move the member out of an MCO to ESP or out of ESP to an MCO as outlined in paragraph 29(e).
viii. A description of the process for ensuring that families do not exceed the 5 percent cost sharing limit as outlined in paragraph 38(c).
ix. A description of the progress made in achieving the $15 million (total computable) in additional savings as outlined in paragraph 58.

c. The State shall submit the draft annual report no later than 120 days after the end of each Demonstration year (DY) for CMS review. The State shall finalize and submit the final draft report within 60 days from receipt of CMS' comments.

58. **Additional Savings Projects.** The State must achieve a total of $15 million (total computable) in additional savings to its Medicaid program by the end of the Demonstration period through enhancements in Medicaid operations such as more effective cost recovery efforts.

The State must report on the progress made in improving the efficiency and economy of Medicaid State operations and achieving the $15 million (total computable) in savings in each Annual Report (as required under paragraph 57). The measures of savings, the baselines from which the savings will be compared, and where the State must report the savings are outlined in the table below. The State may submit an amendment to the Demonstration to modify, remove, or propose additional measures of savings following procedures described in paragraph 8, but will be held to a total of $15 million in savings for the Demonstration period. Savings for each DY will be measured as the difference between the baseline amount and the amount actually reported for that year. If the State does not reach the baseline amount for a particular savings projects for a specific DY, the total DY savings for that project shall be considered ~~–$~~ 0." Each year's savings amounts for each measure will be added together to determine if the State achieved the $15 million target.

Measure	FY 2007 Baseline (Total Computable)	Reporting	Computation of Savings
Third party liability cost recoveries	$ 19,614,846	CMS-64, line 9a	Difference between actual reported amount and baseline
Estate recoveries	$ 9,532,345	CMS-64, line 9b	Difference between actual reported amount and baseline
Collections identified through fraud and abuse effort	$ 4,295,099	CMS-64, line 9c	Difference between actual reported amount and baseline
Strategic Purchasing Agreement for Incontinence Supplies	Medicaid Fee Schedule amount for each product X number of units per product purchased	Total saved amount must be reported in Narrative Section of the CMS-64; details of savings must be reported in the Quarterly Report	Difference between contracted amount and baseline amount X number of units
Strategic Purchasing Agreement for Hemophilia Blood Factor	Estimated Acquisition Cost (Average Wholesale Price minus 16 percent) for each product X number of units per product purchased	Total saved amount must be reported in Narrative Section of the CMS-64; details of savings must be reported in the Quarterly Report	Difference between contracted amount and baseline amount X number of units

The reported expenditures will be reconciled at the end of the Demonstration with the State's Medicaid Budget and Expenditure System (MBES) submissions. If the State does not achieve savings of $15 million by the end of DY 5, the State must return to CMS the Federal share of the difference between $15 million (total computable) and the verified level of savings (total computable). The State will not be required to return more than the Federal share of $15 million. Any repayment required under this paragraph will be accomplished by

the State making an adjustment for its excessive claim for FFP on the Form CMS-64 by entering an amount in line 10(b) of the Summary sheet.

VIII. GENERAL FINANCIAL REQUIREMENTS

59. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the Demonstration under section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.

60. **Reporting Expenditures Under the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

    a. **Tracking Expenditures.** In order to track expenditures under this Demonstration, Indiana must report Demonstration expenditures through the MBES and State Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning January 1, 2008, and ending December 31, 2008. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not Demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base. Expenditures for HHW Caretakers, HHW Children, and HHW Pregnant Women with dates of service December 31, 2007, and before, but with dates of payment January 1, 2008, and after, should be reported on Forms CMS-64.9 Base and 64.9P Base.

    b. **Reporting of HIP Plan Premiums and POWER Account Contributions** The State must report HIP plan premiums and POWER Account contributions as follows:

        i. <u>HIP MCO Premiums.</u> HIP plan premiums must be reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver, using Line 18A.
        ii. <u>State's Contributions to Participants' POWER Accounts.</u> The State's contributions to participants' POWER Accounts must be reported on Forms CMS-64.9 Waiver, using Line 18E. (Because individual participants' POWER Account contributions are collected by the HIP plans, and are not subject to Federal matching, they are not to be reported on the CMS-64.)
        iii. <u>Recouped State Contributions to Participants' POWER Accounts.</u> In the event that the State recoups State POWER Account contributions from HIP MCOs (for example, when a participant disenrolls from HIP; see paragraphs 46.c.ii., 47.b.vii., 48,

49, and 50), the amounts collected must be reported as a prior period adjustment using Line 10B of the Forms CMS-64.9P Waiver on Line 18E.

iv. Forfeited Participant Contributions. In the event that a participant's eligibility for HIP is terminated for non-payment of POWER Account contributions, resulting in forfeiture of 25 percent of the remainder of the participant's share of their POWER Account balance (see paragraph 47(b)(v)), the State must recover the forfeited funds from the HIP MCO and must report the recovery as a collection on Form CMS-64, Line 9D. The State must also provide a supplementary report on the Narrative section of Form CMS-64, stating the amount reported on Line 9D attributable to the recovered participant POWER Account balances, along with a disaggregation of the amount reported by eligibility group, as specified in subparagraph (e).

v. Service Expenditures Through ESP. Expenditures for health care services provided through ESP other than those funded through State or enrollee POWER Account contributions, must be reported on CMS-64.9 Waiver and CMS-64.9P Waiver, by eligibility group, on the appropriate service line. In addition, expenditures for administrative services provided through ESP must be reported on CMS-64.10 Waiver and CMS-64.10P Waiver, by the appropriate eligibility group—"ESP Caretakers Adm" or "ESP Adults Adm," as described in subparagraph (h) below.

c. **Disproportionate Share Hospital (DSH) Expenditures.** The following rules govern DSH expenditures for the Demonstration. All DSH expenditures will continue to be reported on forms CMS-64.9 Base and CMS 64.9P Base.

i. Indiana may not claim FFP of more than $163,721,400 (Federal share) for DSH expenditures for FFY 2008. This amount consists of one-quarter of the full FFY 2008 DSH allotment ($50,333,850 in Federal share) plus three quarters of the State's planned DSH expenditures for a full year. This calculation anticipates a Demonstration implementation date of January 1, 2008. In its proposal, the State indicated that it would spend $151,183,400 (Federal share) on DSH for each year of the Demonstration and would use whatever funds remained up to the State's DSH allotment to fund HIP.

ii. For FFY 2009, Indiana may not claim FFP of more than $151,183,400 (Federal share) plus any FFY 2009 DSH allotment made available through ARRA for DSH expenditures. The increased ARRA DSH allotment for FFY 2009 is $5,254,854 (Federal share).

iii. For FFY 2010, Indiana may not claim FFP of more than $151,183,400 (Federal share) plus any FFY 2010 FFY DSH increases made available through ARRA for DSH expenditures. The increased ARRA DSH allotment for FFY 2010 has not been finalized.

iv. For FFY 2011 and FFY 2012, Indiana may not claim FFP of more than $151,183,400 for DSH expenditures plus any additional FFY 2011 or FFY 2012 DSH allotment that may become available.

v. Indiana may not claim FFP of more than $37,795,850 plus three-quarters of the FFY 2013 DSH allotment for DSH expenditures in FFY 2013. Should the Demonstration be extended beyond December 31, 2012, appropriate adjustments can be made to these requirements in conjunction with the extension. One-quarter of the amount that

Indiana will continue to spend on DSH during each year of the Demonstration is $60,290,078 (total computable) or $37,795,850 (Federal share). Three-quarters of the amount that Indiana will continue to spend on DSH during each year of the Demonstration is $180,870,234 (total computable) and $113,875,550 (Federal share).

d. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

e. **Use of Waiver Forms**. The following five (5) waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. ~~"~~HHW Caretakers" expenditures

ii. ~~"~~HHW Children" expenditures

iii. ~~"~~HHW Pregnant Women" expenditures

iv. ~~"~~HIP Caretakers" expenditures

v. ~~"~~HIP Adults" expenditures

f. **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term ~~"~~expenditures subject to the budget neutrality expenditure limit" refers to all title XIX expenditures on behalf of individuals who are enrolled in this Demonstration, as defined in Section IV, paragraph 19, including all service expenditures net of premium collections and other offsetting collections. All title XIX expenditures that are subject to the budget neutrality expenditure limit are

considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

h. **Administrative Costs.** The following provisions govern reporting of administrative costs during the Demonstration.

   i. In accordance to Federal regulations at 42 CFR 488.812(b)(2), the portion of the State's payments to ESP that is for administrative services must be claimed by the State as an administrative cost at the Federal matching rates available for the costs of administration of the Medicaid program. These administrative expenses are costs of the Demonstration waiver that are subject to the budget neutrality expenditure limit described in section IX of these STCs. These administrative costs must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the DY for which the administrative services were paid. Separate forms must be submitted, using the waiver name ―ESP Caretakers Adm" to report expenses related to the management of HIP Caretakers' services, and ―ESP Adults Adm" to report expenses related to the management of HIP Adults' services.

   ii. Administrative costs attributable to the Demonstration that are not described in (i) must be reported under waiver name ―HIP." These expenses are not subject to the budget neutrality limit.

   iii. Administrative costs not related to the Demonstration should be reported on the appropriate CMS-64.10 Base or 64.10P Base, or another waiver schedule as appropriate, and not subject to the budget neutrality test for this Demonstration.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 Demonstration, in order to account for these expenditures properly to determine budget neutrality.

61. **Reporting Member Months:** The following describes the reporting of member months for HIP:

a. For the purpose of calculating the budget neutrality expenditure limit, the State must provide to CMS, as part of the quarterly report required under Section VII, paragraph 56, the actual number of eligible member months for all HIP eligibility groups defined in

Section IV, paragraph 19. The State must submit a statement accompanying the quarterly report, certifying the accuracy of this information. Member months should be reported only for individuals who are participating in the Demonstration, as defined in Section IV, paragraph 19.

A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for ―HHW Caretakers," ―HHW Children," ―HHW Pregnant Women," and ―HIP Caretakers" are reported in section 6A of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for ―HIP Adults" are reported in section 6B of the template, and are not used to calculate the budget neutrality expenditure limit.

b. The term ―eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member months.

c. ―Eligible member months" does not include the number of months in which an individual participating in the Demonstration cannot access services as a result of reaching the lifetime benefit limits outlined in Section VI, paragraph 37.

62. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

63. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section IX.

a. Administrative costs, including those associated with the administration of the Demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities;

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

64. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

    c. Under all circumstances, health care providers must retain 100 percent of the HIP reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

    d. FFP will not be available for individual contributions to the POWER Accounts. FFP will be available for State contributions to the POWER Accounts, payments to MCOs, and service expenditures through ESP. Payments to the MCOs are based on the assumption of a $1,100 deductible.

65. **Monitoring the Demonstration.** The State shall provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

66. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method, with an aggregate adjustment for projected DSH payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration.

Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section VIII, paragraph 60.

67. **Risk.** Indiana shall be at risk for the per capita cost (as determined by the method described below in this Section) for Medicaid eligibles in the following eligibility groups: ―HHW Caretakers," ―HHW Children," ―HHW Pregnant Women," and ―HIP Caretakers," but not for the number of Demonstration eligibles in each of the groups. By providing FFP for HIP enrollees in these eligibility groups, Indiana shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Indiana at risk for the per capita costs for HIP enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration. Indiana will be at risk for both per capita costs and enrollment for ―HIP Adults" eligibles.

68. **Budget Neutrality Annual Expenditure Limits.** For each DY, two annual limits are calculated.

    a. **Limit A.** Limit A consists of the sum of five components. Components one through three are calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the State in accordance with paragraph 61) for ―HHW Caretakers," ―HHW Children," ―HHW Pregnant Women," each multiplied by the Composite Federal Share (defined below). Component four equals three-quarters of Indiana's Federal share DSH allotment for the FFY that ends during the DY, minus $113,387,550 (Federal share). Component five equals one-quarter of Indiana's Federal share DSH allotment for the FFY that begins during the DY, minus $37,795,850 (Federal share). The calculations used to derive these figures are explained in paragraph 60(c).

    b. **Limit B.** Limit B is calculated as the projected PMPM cost times the actual number of member months for ―HIP Caretakers," multiplied by the Composite Federal Share.

    c. **PMPM Costs.** The following table gives the projected PMPM costs for the calculations described above by DY.

	Trend	DY 1	DY 2	DY 3	DY 4	DY 5
HHW Caretakers	4.40%	$328.07	$342.50	$357.57	$373.30	$389.73
HHW Children	4.40%	$180.51	$188.45	$196.74	$205.40	$214.44
HHW Pregnant Women	4.40%	$476.17	$497.12	$519.00	$541.83	$565.67
HIP Caretakers	4.40%	$312.59	$326.34	$340.70	$355.69	$371.34

    d. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the 5-year approval period, as reported on the forms listed in paragraph 60(e), by

total computable Demonstration expenditures for the same period as reported on the same forms. Should the Demonstration be terminated prior to the end of the 5-year approval period (see paragraphs 10, 12, and 14), the Composite Federal Share will be determined based on actual expenditures for the period in which the Demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

69. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under HIP.

70. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis, by combining the annual limits calculated following paragraph 68 into lifetime limits for the demonstration. The following describes how budget neutrality will be enforced.

    a. Test A consists of application of the combined annual Limits A to Demonstration spending reported on the following schedules, as defined in paragraph 60(e) and 60(g): ~~"~~HHW Caretakers," ~~"~~HHW Children," ~~"~~HHW Pregnant Women," ~~"~~HIP Adults," ~~"~~ESP Adults Adm."

    b. Test B consists of application of the combined annual Limits B to Demonstration spending reported on the ~~"~~HIP Caretakers" and ~~"~~ESP Caretakers Adm" schedule.

    c. If Test A expenditures exceed Limit A, the State must refund excess expenditures from Test A to CMS. Test B savings cannot be used to offset excess expenditures from Test A.

    d. If Test B expenditures exceed Limit B and Test A shows savings, a second test is performed by combining Tests A and B. The State must refund excess expenditures (if any) from the combined test to CMS.

    e. If both Tests A and B show excess expenditures, the State must refund the excess expenditures from both tests to CMS.

    f. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the State's compliance with these requirements shall be based on the time elapsed through the termination date.

    g. **Interim Checks/Corrective Action Plan.** If the State exceeds the calculated cumulative target limit for both Tests A and B combined by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 1	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 2	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 3	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 4	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 5	Cumulative budget neutrality expenditure cap plus:	0 percent

X. EVALUATION OF THE DEMONSTRATION

71. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

    The State shall ensure that the draft evaluation design will address the following evaluation questions:

    1. How many HIP participants reach their $300,000 annual benefit limit each year? How do these individuals meet their health care needs during the period of exhaustion of their benefit and the beginning of the next coverage term?
    2. How many HIP participants reach their $1,000,000 lifetime benefit maximum? How do they go about meeting their health care needs after their HIP benefits are exhausted?
    3. What are the consequences of limiting participants' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCO?
    4. How many enrollees are reassigned from HIP MCOs each year to ESP? How many are reassigned from ESP to a HIP MCO?
    5. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
    6. What are the consequences of requiring HIP participants with family income less than 150 percent of the FPL to pay monthly premiums? How many of these participants fail to make their first POWER Account contribution? How many of these participants are disenrolled for failure to pay their premiums?
    7. To what extent has HIP impacted the uninsurance rate in Indiana?
    8. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
    9. How many enrollees exhaust their POWER Account each year? How many enrollees are able to roll-over a sufficient POWER Account balance to reduce their subsequent

year's required contribution by at least half? How many enrollees are able to achieve a $0 contribution by this means?

72. **Interim Evaluation Reports**. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

73. **Final Evaluation Design and Implementation**. CMS must provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

74. **Cooperation with Federal Evaluators**. Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date – Specific	Deliverable	STC Reference
5/01/2008	Submit Draft Evaluation Design	Section X, paragraph 73
1/01/2009	Submit confirmation that HIP members will have a choice of at least two managed care organizations.	Section VI, paragraph 31
6/30/2012	Submit Demonstration Application	Section II, paragraph 9
6/30/2012	Submit Interim Evaluation Report	Section X, paragraph 72

	Deliverable	STC Reference
Annual	By May 1st - Draft Annual Report	Section VII, paragraph 57
Quarterly		
	Quarterly Progress Reports	Section VII, paragraph 56
	Quarterly Expenditure Reports	Section VIII, paragraph 59
	Eligible Member Months	Section VIII, paragraph 61

Attachment A

Quarterly Program Report Guidelines

Under Section VII, paragraph 56 of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Healthy Indiana Plan Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (1/01/08 - 12/31/08)
Federal Fiscal Quarter: 2/2008 (1/08 - 3/08)

Introduction:
Information describing the goal of the demonstration, what it does, and key dates of approval/ operation. (This should be the same for each report.)

Eligibility and Enrollment Information:
Please provide the following information. If there was no activity under a particular facet of the tables below, the State should indicate that by ~~0~~."

1. The number of HIP members who have reached $200,000 in benefits in a year or $900,000 in benefits in a lifetime. Of these individuals, how many have been referred to the regular Medicaid program, Medicaid for Employees with Disabilities (M.E.D. Works), or ICHIA, the State's high-risk pool.

2. The number of HIP members who have reached the $300,000 annual and $1 million lifetime benefit limits during the quarter. Of these individuals, how many were determined eligible for the regular Medicaid program, and thus have continued coverage available despite having reached their coverage limit? Of these individuals who were not determined eligible for regular Medicaid, how many were determined eligible for M.E.D. Works, and how many were determined eligible for ESP?

3. The number of HIP enrollees who are receiving benefits through ESP.

4. Report on the number of HIP applicants and the disposition of their applications, by income relative to FPL, using the following table:

Attachment A

Quarterly Program Report Guidelines

FPL Level	Column A: Number of Hoosier Healthwise or HIP Applicants	Column B: Number enrolled in the Hoosier Healthwise program	Column C: Number enrolled with a HIP MCO	Column D: Number enrolled in ESP	Column E: Number of enrollees who failed to make POWER Account contribution and were terminated.	Column F: Number of applications declined due to a finding of ESI access or health insurance in the last 6 months
0-22% FPL						
22-50% FPL						
50-100% FPL						
100-150% FPL						
150-200% FPL						

5. Report on HIP enrollment numbers using the following table:

Attachment A

Quarterly Program Report Guidelines

FPL Level	Column A: Number of persons enrolled at start of quarter	Column B: Number of persons enrolled during quarter	Column C: Number of persons disenrolled for non-payment of POWER Account	Column D: Number of persons disenrolled at end of coverage term for failure to recertify	Column E: Number of persons disenrolled for other reasons	Column F: Number of persons enrolled in HIP at the end of the quarter (F)=(A)+(B)-(C)-(D)-(E)
0-22% FPL						
22-50% FPL						
50-100% FPL						
100-150% FPL						
150-200% FPL						

6. Report member-months for budget neutrality:

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
HHW Caretakers				
HHW Children				
HHW Pregnant Women				
HIP Caretakers				

B. Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
HIP Adults				

Outreach/Innovative Activities:

Attachment A

Quarterly Program Report Guidelines

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **No. 11-W-00237/5**

TITLE: **Healthy Indiana Plan (HIP) Medicaid Section 1115 Demonstration**

AWARDEE: **Indiana Family and Social Services Administration (FSSA)**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the State plan mandatory and optional populations. In addition, the provisions of the Social Security Act (the Act) specifically listed as waived in this list are ―not applicable" to the Demonstration populations made eligible through expenditure authority, as specified in the individual waivers.

The Demonstration will operate under these waiver authorities and those provisions specified as ―not applicable" beginning January 1, 2008. The waiver authorities and the provisions specified as ―not applicable" will continue through December 31, 2012, unless otherwise stated.

The following waivers and references to the Act specified as ―not applicable" shall enable Indiana to implement the HIP Medicaid section 1115 Demonstration.

<u>Title XIX Waivers</u>

1. Statewideness/Uniformity **Section 1902(a)(1)**

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the Hoosier Healthwise program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in Hoosier Healthwise.

3. Freedom of Choice **Section 1902(a)(23)**

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

4. Disproportionate Share Hospital (DSH) Payments **Section 1902(a)(13)(A) insofar as it incorporates Section 1923(c)(1)**

To the extent necessary to allow Indiana to divert of a portion of DSH payments made to hospitals to cover the demonstration population.

STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Mitchell E. Daniels, Jr.
Governor

December 28, 2011

The Honorable Secretary Kathleen Sebelius
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

The State of Indiana has operated the successful and popular Healthy Indiana Program (HIP) under an 1115 waiver for four years. We believe it has more than met the goals of a demonstration program to show conclusively that the Medicaid population is well served by a consumer driven health plan. Participants have responded positively to the prevention strategies we employ and have made more appropriate utilization of the health care system.

Today, on behalf of the 50,000 current HIP participants and the approximately 500,000 Hoosiers who will be newly eligible to receive Medicaid in 2014, we are submitting a request to extend the Healthy Indiana Plan (HIP) through an 1115 waiver request for the maximum allowable time period. This year, the Indiana Legislature passed a law (Indiana Code 12-15-44.2), on a bi-partisan basis, that calls for HIP to be the coverage vehicle for the Medicaid expansion in 2014. Our intent is to make HIP a permanent part of our Medicaid program. However, due to the delinquent release of regulations, your agency was unwilling to respond to our original request to amend our State Medicaid Plan. This waiver submission is our final attempt to save the HIP program.

HIP has proven to be far superior to a traditional Medicaid program. Over 99% of HIP participants that were surveyed would re-enroll in the program. Eighty percent of HIP participants completed their preventive services required for their personal POWER account rollover. Members have lower non-emergency ER use versus the traditional Medicaid population, higher generic drug use than a comparable commercial population, and over 97% pay their required contributions on time. HIP gives dignity to its participants. It believes in their ability to make consumer driven choices and value based decisions when they seek health care.

Because of the new federal law, Indiana will have to absorb between 350,000 and 500,000 new Medicaid participants in 2014. When combined with current participants, almost a fourth (1.5M individuals) of the state's population will be served by Medicaid. Should the Supreme Court uphold the Affordable Care Act and the Medicaid expansion, collectively our State's leadership believes that new Medicaid participants should not be consigned to a traditional paternalistic program that fosters dependency, raises costs and does not improve health outcomes.

The HIP waiver expires on December 31, 2012. While advocating for the passage of the Affordable Care Act, President Obama said, "If you are happy with your health insurance, you can keep it." We are hopeful you will prove that the administration will honor that commitment by granting our request. If your agency does not approve our waiver request, you will be ending coverage for thousands of Hoosiers. This transition, as outlined in our waiver, will take at least six months and therefore, we request a response no later than June 30, 2012.

Sincerely,

/Mitchell E. Davis/

Mitchell E. Daniels, Jr.

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Michael A. Gargano, Secretary

December 27, 2011

Cindy Mann, JD
Deputy Administrator
Center for Medicare and Medicaid Services
Director
Center for Medicaid CHIP, and Survey and Certification
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244

Dear Director Mann:

The attached 1115 waiver renewal submission contains the required documents to request the Healthy Indiana Plan (HIP) be renewed for the maximum allowable time. The current HIP 1115 Waiver expires December 31, 2012. The submission includes changes and additions authorized by the Indiana General Assembly and requests the program be the coverage vehicle for the Patient Protection and Affordable Care Act (PPACA) required Medicaid expansion. The authorizing language can be found at Indiana Code 12-15-44.2.

The renewal request was prepared per the process outlined in the proposed rules for 1115 Waiver submission published in the federal register March 14, 2011. The process included a public comment period, and the feedback received is summarized in this application. The renewal request also incorporates the language from the August 11, 2011 Medicaid Eligibility proposed rule surrounding the new 'Adult' group.

Thank you for your consideration of our 1115 waiver renewal submission. We look forward to working with you to approve our waiver renewal.

Regards,

/Michael A. Gargano/

Michael A. Gargano
Secretary

/Patricia Casanova/

Patricia Casanova
Medicaid Director

cc. Verlon Johnson; Marilyn Tavenner

Indiana Family and Social Services Administration

Healthy Indiana Plan 1115 Waiver Extension Application

Submitted
12/28/2011 -

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Section 1: Executive Summary

The groundbreaking Healthy Indiana Plan 1115 waiver demonstration expires in December 2012 and per the Centers for Medicare and Medicaid Services (CMS) guidelines the State must submit requests for waiver extensions 12 months before waiver expiration. To this end, Indiana submits this request to extend the successful Healthy Indiana Plan (HIP) for the maximum waiver renewal period of 3 years. The State's intent is to make HIP a permanent part of the Medicaid program for non-disabled adults. In 2010, the Indiana Legislature passed Senate Enrolled Act 461, which became Indiana Code (IC) 12-15-44.2, calling for HIP to be the coverage vehicle for the newly eligible Medicaid population under the ACA. Since CMS did not approved our state plan amendment request we have no choice but to use the waiver process to continue this effective program. As a result of the recent changes to Medicaid eligibility initiated by the Patient Protection and Affordable Care Act (PPACA) and changes requested by the Indiana General Assembly, this waiver renewal application includes minor modifications to HIP, as well as a request for HIP to serve as the coverage vehicle for individuals newly eligible under the PPACA Medicaid expansion, should PPACA withstand the Supreme Court challenge.

The HIP demonstration project was approved in December 2007, and the program began January 1, 2008. HIP covers caretaker and non-caretaker adults up to 200% of federal poverty level (FPL). [1] HIP represents one of the first Medicaid demonstration projects that worked towards harnessing the promise of consumerism through member participation to incentivize positive health behaviors and improve health outcomes. The program created Personal Wellness and Responsibility (POWER) accounts modeled after Health Savings Accounts (HSA) to encourage enrollees to be consumers of health care services that evaluate cost and quality. Over three years later, HIP has demonstrated significant success in achieving its goals and remains the sole Medicaid demonstration project modeled on the principals of consumer-driven health plans.

In 2010, the Indiana Legislature passed Senate Enrolled Act 461, which became Indiana Code (IC) 12-15-44.2, calling for HIP to be the coverage vehicle for the newly eligible Medicaid population under the ACA. This legislation also adds a requirement for enrollees to make a minimum contribution to their POWER account of $160 annually, allows not-for-profits to make up to 75% of the members required contribution to the POWER account, authorizes Managed Care Entities (MCEs) to contribute to the POWER account to incentivize positive health habits, and changes HIP eligibility from 200% FPL to align with the ACA expansion limit of 133% FPL starting in 2014. The $160 annual contribution will still be subject to requirements in IC 12-15-44.2 that stipulate that enrollees may not spend more than 5% of their income in contributions and copayments for health care; for individuals who reach the 5% limit contribution requirements will be suspended.

[1] Caretakers are a categorically eligible Medicaid population; these individuals have a dependent under the age of 19. Non-caretakers are adults without dependents under the age of 19 that the HIP waiver grants the State permission to cover to an enrollment cap of 36,500 individuals, contingent upon the waiver's budget neutrality agreement.

Over the first three demonstration years, HIP has demonstrated success. Between January 2008 and December 2010, HIP served 77,466 Hoosiers. In two separate independent evaluations of the program, HIP members have shown high satisfaction and member satisfaction surveys conducted by the contracted health plans show satisfaction rates greater or comparable to commercial plans. The HIP program has noted differences in care utilization patterns compared with traditional Medicaid programs, including greater use of preventive care, lower Emergency Room (ER) use, and increased utilization of generic pharmaceuticals. Eighty-percent of HIP enrollees complete the preventive services required for a POWER account rollover and over the first 12 months of enrollment HIP member non-emergency utilization of the ER decreases by 14.8%.[2]

HIP demonstrates that requiring contributions of members results in significant differences in utilization behavior. Within HIP itself, differences in care utilization have been observed between members who contribute to their POWER account and members who do not contribute, suggesting that making contributions has significant impacts. Non-contributors overall have a higher use of ER services and non-emergency ER visits that could be partially explained by not having to pay into POWER accounts. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members. The non-contributing population in general suffers from higher morbidity; however, the POWER account contributions and the influence of consumerism cannot be ruled out as factors contributing to this vast difference in utilization.[3]

HIP policies to promote personal responsibility have also had a positive impact. HIP incents individuals to obtain preventative health care by allowing the entire balance (State and individual's contribution) of their POWER Account to rollover, reducing their required contribution. To this end, members have engaged in positive health behaviors including seeking preventive services at rates higher than comparable Medicaid populations, decreasing their non-emergency use of the ER, and increasing their utilization of services offered by primary care physicians. HIP members are aware of their POWER account balance and supportive of the program: 94% are satisfied or highly satisfied with their coverage, and 99% of HIP enrollees would choose to reenroll in the program.[4] Survey data collected by Mathematica in 2010 suggests that the majority of respondents knew key features of the program. For example, most HIP members were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it.

HIP policy requires that individuals make their monthly contributions within 60 days or face expulsion from the program for 12 months. The vast majority of members pay their POWER

[2] Data from Mathematica Data Enclosure, December 2010.

[3] *Ibid.*

[4] Product Acceptance Research Telephone Survey of HIP members, 2009.

account contribution on time, and during the first two years of the program only 3% of enrollees were disenrolled for failing to pay their POWER account contribution. While in 2010 this number grew to 8% of enrollees, data for the first half of 2011 shows a decrease back to the 3% level. In addition to POWER account payments, enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85% of HIP enrollees submitted redetermination packets on time. For the third year of the demonstration, 2010, 96% of enrollees submitted their redetermination packet on time. These results suggest that HIP's policies encourage members to engage in their health care and that the members value the program.

Eligibility and budget neutrality requirements would remain the same in 2013, but the State requests that disproportionate share hospital payments (DSH) not be diverted, since the State can achieve budget neutrality without these funds. With the changes in Medicaid eligibility in 2014, the caretaker and non-caretaker categories under HIP become the 'adult group';[5] and this waiver renewal application reflects the changes in the Notice of Proposed Rulemaking (NPRM) on Medicaid program changes published in the federal register August 17, 2011. Starting in 2014, if the PPACA stands, all individuals under 133% FPL receive Medicaid coverage. The State would like to designate HIP as the vehicle to cover this newly eligible Medicaid population. The State requests minor modifications to the waiver and budget neutrality agreement to correlate with the recent legislation and the ACA.

The HIP program ends December 31, 2012, without a waiver extension. The State will need at least six months to dismantle the program. Therefore, we ask that CMS make its decision by June 30, 2012, so we can make the necessary preparations.

Section 2: Program Description and Background

HIP provides an alternative to traditional Medicaid and is the nation's first consumer-driven coverage program for low-income adults. HIP features a comprehensive high deductible health plan and a modified Health Savings Account (HSA) called the POWER account, which invites members to be thoughtful and engaged health care consumers. Contingent on payment of a monthly contribution to their POWER account, the current waiver provides HIP eligibility to Hoosiers between the ages of 19 and 64, earning below 200% FPL, who have not had access to employer sponsored insurance for at least six months.

As covering deductible costs is a known challenge for low income populations, HIP modifies the traditional HSA model to make it compatible with low income needs and limitations. First, the State subsidizes the POWER account to ensure the account is fully funded, up to the amount of the deductible. It requires health plans to provide payment to providers for deductible costs, even

[5] As described by the *Medicaid Program: Eligibility Changes under the Affordable Care Act n*otice of proposed rulemaking at 435.119.

though the account may not contain the individual's full annual contribution. The State also ensures that the deductible is not a barrier to recipients receiving preventive services, as the first $500 in preventive services are provided outside the deductible. While HIP contributions are not tax deductible, most participants are below federal poverty level and would not avail income tax benefits from tax deductible contributions.

After a $1,100 deductible is met, the HIP program includes comprehensive health plan benefits up to $300,000 annually and $1,000,000 lifetime which are waived from certain benchmark requirements.[6] Instead of traditional cost-sharing of premiums and copayments, HIP participants make upfront contributions for their health care through required POWER account contributions. The funds contributed to the POWER account are used to pay for deductible expenses. Contributions are based on a sliding scale so that individuals can afford to make the monthly payments but still have "skin in the game." The program ensures that no participant pays more than 5% of their income, consistent with CMS rules. Employers are also allowed to contribute up to 50% of the required contribution. Participants have control over how POWER account dollars are spent and receive monthly statements on POWER account expenditures and account balances. If participants fail to make their contributions within sixty days, they are removed from the program and may not reenroll for twelve months. Unlike traditional premiums or copayments, HIP members own their contributions and are entitled to any unused contributions if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by allowing any remaining balance--including the State's contribution-- in their POWER account to rollover and offset required contributions in the next year. If individuals do not complete the required preventive services only the pro-rated balance of their individual contribution rolls over. Any rollover amount can reduce required contributions in the following year. The incentive is designed to increase the use of preventive care. In the long term, the regular use of preventive services under the HIP program should reduce costs and improve the health of the individual and population.

HIP provides comprehensive benefits including physician, inpatient, outpatient, mental health services, pharmaceuticals, labs, and other therapies. HIP requires copayments for non-emergency use of the emergency department; these copayments vary from $3 to $25 dependent on an individual's caretaker status and his or her federal poverty level (FPL). Different from traditional Medicaid programs, individuals are provided with monthly POWER Account statements and Explanations of Benefits that explain costs of care. These provisions are aimed at increasing members' awareness of the cost of care and promoting consumerism and efficient care seeking behavior.

HIP promotes personal responsibility by requiring that members are timely with payments and eligibility paperwork submission; otherwise, enrollees face a twelve month penalty period before

[6] HIP is not a benchmark plan due to the lack of maternity and dental coverage, and the annual and lifetime coverage limits.

they may reenroll in the program. This also ensures that individuals do not enroll only when they are ill and require treatment and then drop coverage when they recover. HIP provides reimbursement to healthcare providers at Medicare rates, which in Indiana are higher than traditional Medicaid, thus encouraging a more robust provider network. These increased rates also improve enrollee access to care. HIP's progress towards meeting its program goals will be discussed later in this document.

Section 3: Historical Narrative

In 2006, Indiana ranked second in the nation for incidence of adult smoking, had poor general health indicators, and a low rate of preventive care utilization. Additionally in 2005, 860,000 individuals[7] had been without health insurance in the last year, and 62% of these uninsured were working age adults below 200% FPL.[8] Prior to HIP, the Indiana Medicaid program had one of the lowest eligibility thresholds in the nation and only covered non-disabled caretakers up to 23% of FPL. There was little support to expand the State's traditional Medicaid program as an open-ended entitlement that could strain the State's budget in future years Additionally, a traditional Medicaid plan had questionable ability to significantly improve the health status of individuals, a lack of incentives for participants to utilize health care appropriately, and the structure did not promote personal responsibility. While consumer driven health plans and HSAs were used in the commercial marketplace, they had not been used for low-income populations. Based on input from numerous stakeholder meetings, Governor Mitch Daniels instructed his staff to design a health care plan that incorporated health care consumerism and private market principles. This ensured the maintenance of a balanced State budget by not creating an open-ended entitlement program, and promoted health for Hoosiers.

Governor Daniels presented the design of the HIP program to the public in November of 2006. Once proposed, Republican State Senator Pat Miller and Democrat State Representative Charlie Brown championed the effort and sponsored House Bill 1678 during the 2007 session of the General Assembly. Through their leadership, the Indiana Check-Up plan, which contained the enabling legislation for HIP, passed with bipartisan support with votes of 70-29 in the House of Representatives and 37-12 in the Senate. HIP's enabling legislation only permits the State to enroll as many individuals as its funding can support to ensure long term budget sustainability. HIP enrollment is constrained by the number of dollars generated through a cigarette tax increase included in the enabling legislation that funds the program. This tax increase simultaneously discourages smoking and youth smoking in the State has declined since the passage of the law.

After the bill was passed in April 2007, the Family and Social Services Administration (FSSA) moved immediately to develop an implementation plan and began negotiations with CMS to obtain

[7] U.S. Census Bureau, Current Population Survey (CPS), 3-year average, 2003-2005.

[8] State Health Access Data Assistance Center (SHADAC), University of Minnesota, *2003 Health Insurance for Indiana's Families Summary* (August 2003).

federal waiver approval. HIP began enrolling working-age, uninsured adults on January 1, 2008, seven months after passage of the enabling legislation and less than a month after receiving approval for the program from the CMS.

An unforeseen challenge of HIP was the pent-up demand for services in the uninsured population. Initially, the HIP population used services at a greater rate than the traditional Medicaid population, likely due to untreated disease in this previously uninsured population. However, since inception, HIP members have taken advantage of preventive services, lowered their non-emergency ER use, and learned to manage their chronic conditions through the use of prescription medications. Over the course of HIP, the program has met and exceeded the State's performance expectations. The State remains committed to HIP as a program that provides quality care to low income individuals while embracing the principals of consumerism.

3.1 Contract Modifications

HIP has evolved over the course of the demonstration. At the beginning of the program, HIP contracted with two MCEs, Anthem and MDwise and had a third Enhanced Services Plan (ESP) that is separate but is operated by the State's high risk pool, the Indiana Comprehensive Health Insurance Association (ICHIA), to provide coordinated coverage for HIP members with high risk conditions. During the first three and a half years of the program, the contracts governing the State's relationship with Anthem and MDwise were modified to contain costs, better serve members, streamline ESP, and ensure that the MCEs remained on stable financial footing.

The initial contracting period in 2007 selected two managed care plans Anthem and MDwise, in collaboration with AmeriChoice,that leveraged commercial experience and HSA experience. However, in the 2009 contract year, MDwise changed subcontractors to ACS which handles MDwise claims processing and member billing. Acting in some capacity as a third health plan option ESP is administered on an ASO basis through ICHIA.

In 2008, both Anthem and MDwise ended the year with losses as the capitation rates did not reflect the pent-up demand for services and high disease burden of a previously uninsured population. Non-caretakers in general had higher costs than caretakers. The State amended the risk-sharing arrangements in their 2009 HIP contracts. The amended contracts included higher monthly capitated rates for caretakers and a stop-loss provision for non-caretakers (effective retroactively to January 2009), and new criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009. The losses were due to the high morbidity of a previously uninsured population and pent-up demand of the early entrants, especially amongst the non-caretaker population where no Medicaid coverage existed. Actuarial analysis conducted on the first year of program claims experience showed that caretakers had a 25% higher risk adjusted relative morbidity than the commercial population, and non-caretakers had an even higher morbidity at 65% greater than a comparable commercial population. These populations also initially used services at a much higher rate, compared to a commercial population.

Caretakers initially had 38% more inpatient hospital days and 181% more ER visits, and non-caretakers had 155% more inpatient hospital days and 269% more ER visits. Over the course of the first year of enrollment, HIP members increased their use of pharmacy services and decreased their use of all other services, with the decline in utilization beginning in approximately the third month of enrollment.[9] This pent-up demand for services has been challenging for health plans to manage. However, over the three year life of the program, the health plans have seen high inpatient costs replaced with more outpatient visits and use of prescription drugs, which has decreased costs.

The 2010 HIP contracts included a carve-out for most pharmacy services. The carve-out for pharmacy costs helped the State meet and exceed the budget neutrality requirements. The State consolidated into one contract all the pharmacy purchasing for Medicaid programs. This consolidation was done to maximize rebate savings available to the State, as well as to achieve administrative simplifications, and thus savings, on prescribing, dispensing, claims submission, program analytics, and prior authorization for pharmaceuticals. For members, this new arrangement provides access to an expanded list of pharmaceuticals, including brand-name pharmaceuticals. For providers, it streamlines the prescribing system, moving from multiple distinct lists of preferred drugs for different public programs and plans, to one list. This shift utilizes one set of prior authorization requirements, one claims processing methodology, and one help desk. Thus far, both vendors are working closely with the State and the State has established a good working relationship with these vendors.

The negotiations for the 2011 health plan contracts addressed the costs of care. Both Anthem and MDwise are reporting declines in utilization and more predictable costs now that the population has access to routine and preventive health care services.

The 2011 contracts represented the first time the State combined HIP and Hoosier Healthwise (HHW) into one contract. HHW serves the State's non-waiver Medicaid managed care populations. The State's purpose is to integrate contracts to gain some program efficiencies and to make the programs seamless for families who have some members in HHW and others in HIP. As a result, the State views both programs as more family friendly. The new contract developed this integration and requires plans to maintain one call center for both programs, a way of offering 'one stop shopping' to families with members in both the HIP and HHW programs. Unifying the programs also brings administrative simplification for providers, as the new contract aligns all policies and procedures in the two programs (although provider reimbursement remains based on Medicare rates in the HIP). The State believes the new contracts will bring a focus on family health to both programs.

[9] Damler, R. *Experience Under the Health Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured.* Milliman Inc. (August, 2009).

During the 2011 process the State selected three plans to serve the HIP population. Anthem and MDwise continue to serve HIP, and the State added Managed Health Services (MHS), which has traditionally served Indiana's Medicaid Hoosier Healthwise population. Under the new contracts, the plans must implement a debit swipe card for HIP members. The cards are to be used at the point-of-service to verify eligibility, whether the service is covered, and whether the provider is participating in the HIP. The card is linked to their POWER accounts, and members should be able to assess at the point of service what their contribution to the costs of the services will be (i.e., what will be deducted from their POWER accounts). The debit card is intended to enhance the experience of using the POWER account and promote consumer driven healthcare. MHS operationalized the card as of January 1, 2011 and the other plans will implement the card in 2011. All debit cards were required to have the capability for eligibility determination and cost estimation as of July 1, 2011, with full implementation of the debit card in place by January 1, 2012.

3.2 Enhanced Services Plan (ESP)

The ESP was designed to reduce risk for the health plans and to lower capitation rates to the health plans. Initially ESP participants were to represent the top 1% of risk in the HIP population. Through modifications to the ESP program this population currently represents the top 3% to 5% of risk in the HIP population. While receiving all the same HIP services and benefits, these high risk individuals are managed by the State's high risk plan, ICHIA, with experience in managing high cost health conditions. The HIP population is separate from the State's high risk pool.

HIP's higher than expected initial cost of care, which partly result from pent-up demand and the higher morbidity and co-morbidities of a previously uninsured population, drove the State to identify ways of reducing the risk to the health plans. One means of attaining this goal was to expand the list of conditions that would qualify an individual to participate in the ESP and simplify referral processes to make ESP determinations timelier. Originally, ESP was accessed when a high risk condition was reported and verified and the State contracted with a vendor to interview the patient to determine if the ESP placement was appropriate. To make access to ESP more convenient, the State altered several enrollment policies and expanded the list of qualifying conditions in July 2009. When HIP applicants check one of the qualifying conditions on the application, they are now automatically enrolled in the ESP and stay enrolled until their eligibility is redetermined. If their claims history at redetermination confirms the information reported on the application, they will stay with the ESP; otherwise, they will be transitioned to one of the other health plans. In addition, the plans now have six months to refer a member to the ESP, as opposed to 60 days in 2008. In July 2009, when the new policies took effect, Anthem and MDwise reviewed their claims records, applied Milliman's underwriting guidelines, and scored their members. Those members found to have an ESP qualifying condition and a risk score at or above a certain threshold were transferred to the ESP at that time. This process is expected to continue for the life of the waiver and no changes are requested.

3.3 Application Processing

At two different times during the first year of program operations, the State's vendor struggled to keep up with the flow of applications—more than 120,000 were submitted in CY 2008 (yielding more than 35,000 enrollees). At program initiation, high enthusiasm for the program, assertive outreach and advertising and pent-up demand led to more than 18,000 applications being submitted in just the first month. The State's vendor adjusted staffing to accommodate this initial surge in interest, but the queue again lengthened during the second half of 2008. Part of the challenge in managing applications may have been that HIP's launch coincided with a major initiative to upgrade enrollment and eligibility business processes affecting all public assistance programs operated by the Family and Social Services Administration (FSSA). To address the issue, additional eligibility staff was hired in January 2009. The application processing delays seen in the first demonstration year did not substantially slow enrollment. For example, by March 2009 HIP was approaching the enrollment cap (34,000) for non-caretaker adults, a level that the State had not expected to reach until the third or fourth year of the demonstration. To manage enrollment levels, and to ensure the State could maintain budget neutrality, the State closed enrollment for non-caretakers in March 2009.

The State also made significant progress in 2009 with the HIP application backlog. HIP operations staff worked to resolve various issues and have identified approaches to expedite their resolution. In late 2009, the State hired an additional 18 state eligibility consultants (SECs), who were brought on in January 2010. They have increased the percentage of applications processed in a timely manner from 71% in May 2009 to 88% as of December 2010. In the second quarter of 2009, the State developed a revised dashboard to include more information on the HIP application processing and to showcase different aspects of the HIP program.

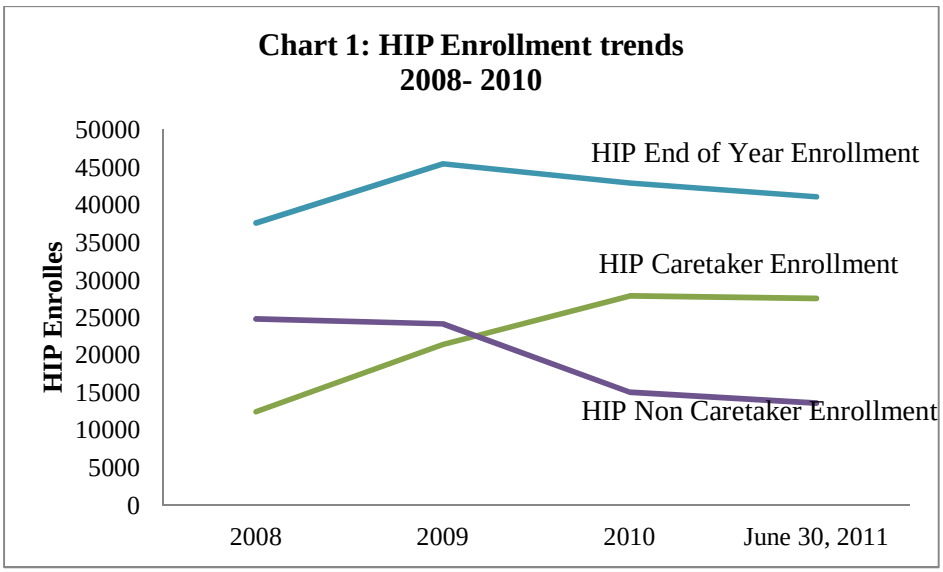
3.4 Non-caretaker Waitlist

The waiver agreement imposed a cap on the number of non-caretakers who could enroll in the program. On March 12, 2009, HIP closed enrollment to non-caretakers. At that time, the number of non-caretakers members had reached 32,000, just below the 34,000 cap established in the Special Terms and Conditions (STC). Enrollment for non-caretakers was closed before the cap was reached to ensure that applicants in the eligibility determination process or appealing denied applications and any pregnant woman who after delivering lost HHW eligibility could be enrolled in HIP without exceeding the cap. At the same time, all new applications from non-caretakers were reviewed for eligibility and placed on a waiting list if determined eligible. CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers. The State opened 5,000 non-caretaker slots in the fall of 2009 and sent letters to the first 5,000 applicants on the waitlist in November 2009. The invited applicants started the enrollment process by reapplying for HIP and having their eligibility for the program redetermined. With the passage of the Affordable Care Act in March 2010, HIP enrollment of non-caretaker adults remained closed due to the Maintenance of Effort (MOE) provisions contained in this legislation and concern that since the program could not

be closed to caretakers, the State could be forced to cover costs beyond the funds that were available from the cigarette tax fund. Based on declining enrollment of non-caretakers, the State initiated the opening of an additional 8,000 slots to individuals on the waitlist in August 2011. The waitlist for non-caretakers was 50,155 as of June 30th, 2011.

3.5 Enrollment Trends

In the first three years of the HIP program, the State received a total of 309,847 applications and 77,466 people had been enrolled. In 2008, the first year of program operations, the State received 120,313 applications. Submitted applications dropped off in 2009 with 72,282 being submitted but picked back up again in 2010 with 117,252 submissions. As of June 30th, 2011 17,490 applications have been received in 2011.



The chart above shows the end of year enrollment trends for the first three years of the HIP program. The decline in non-caretaker enrollment and the increase in caretaker enrollment is apparent. HIP enrollment was 37,568 at the end of 2008, 45,460 at the end of 2009, 42,872 at the end of 2010 and current enrollment as of June, 30th 2011 is 41,062. The program's population is divided into caretaker and non-caretaker groups. As the program has progressed the percentage of caretakers ever enrolled has increased in comparison to the non-caretakers enrolled. For those ever enrolled in HIP in 2010 56% were caretakers and 44% were non-caretakers. By comparison, at the end of 2008 67% of enrollees were non-caretakers and 33% of enrollees were caretakers. As of June 2011, 67% (27,364) of enrollees were caretakers and 33% (13,698) were non-caretakers.[10]

Over the course of the HIP program the majority of members have been under 100% FPL. Member distribution by FPL in June 2011 is consistent with the previous trend: 69% of HIP

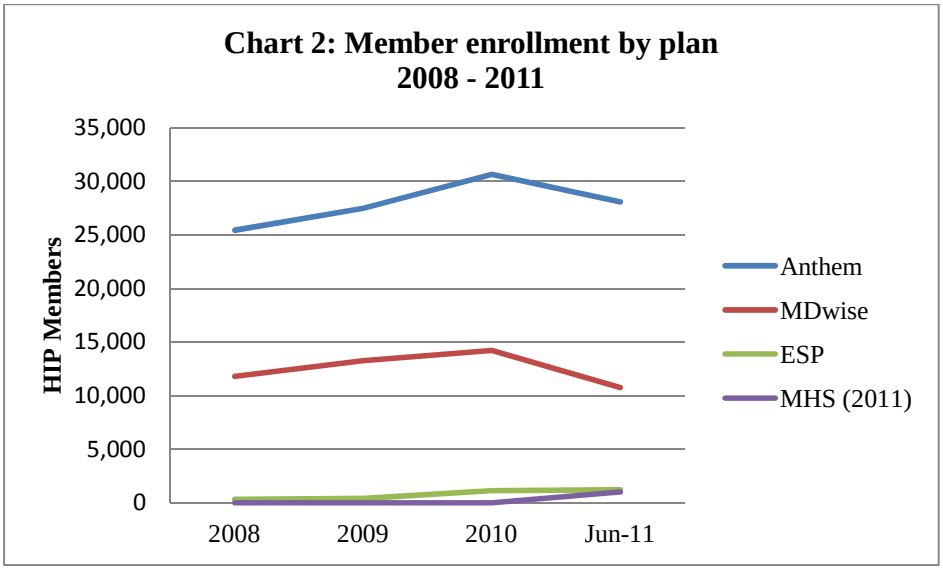
[10] Annual data from annual HIP reports. June data from June HIP Dashboard.

enrollees are currently at or under 100% FPL. HIP has only had 10% to 15% of enrollees on an annual basis that are over 150% FPL.

Table 1: HIP Enrollee Distribution by FPL: Members ever enrolled[11]

FPL	2008	2009	2010
<100% FPL	26,969 72%	41,795 71%	37,061 62%
101 – 150% FPL	6955 19%	11,432 19%	13,849 23.1%
>150% FPL	3,620 10%	6,079 10%	9,015 15%
TOTAL	**37,544 100%**	**59,306 100%**	**59,945 100%**

When found eligible HIP members are able to select Anthem, MDwise or MHS as their plan, or they are placed into ESP if they identify that they have a high risk condition. Over the first three years of the program (2008 to 2010) between 68% and 70% of members have enrolled in Anthem, and 30% to 32% have enrolled in MDwise. With the changes to the ESP assignment process the percentage of HIP members enrolled in ESP increased from 1% to 3% between 2009 and 2010. This rate has held steady and in June of 2011 3% of HIP members were enrolled in ESP. The current demonstration year (2011) is the first year of the HIP program that has had a third managed care option for members to choose from. As of June 2011 approximately 3% of HIP enrollees were enrolled in MHS. Anthem maintained 68% of HIP enrollment and the percent of members enrolled in MDwise dropped to 26%.



[12]

[11] Data from HIP Annual Reports 2008-2010.

Over the course of the HIP program, member distribution by gender has been steady though one gender has been predominant. Sixty-three percent (63%) of enrollees are female and 37% of enrollees are male. Geographically, HIP members are distributed throughout the state, with higher concentrations in Indiana's population centers and overall enrollment reflects the population density of the state.[13] Similarly, member distribution by race has, over the course of the program, closely aligned with the distribution of working age uninsured adults under 200% FPL in Indiana.[14] From January 2008 to June 2011 the percentage of enrollees who identified as white varied from 82% to 84% and the members who identified as black varied from 10% to 13% with Hispanic, Native American and others making up the remainder. Age distribution has also been relatively steady throughout the course of the program. From 2008 to June 2011 member age distribution has skewed towards more aged individuals with those under 30 representing the smallest proportion of HIP members.

Table 2: Percentage Member distribution by age

Age	2008	2009	2010	June 2011
<30	19.3%	20%	15%	13.9%
30-39	21.4%	25%	29%	29.8%
40-49	26.6%	27%	28%	29.9%
50+	32.9%	28%	28%	26.4%

*Data from HIP Annual Reports 2008 – 2010 and HIP June dashboard

3.6 Benefit Limit

HIP includes an annual limit of $300,000 in benefits and a lifetime benefit maximum of $1,000,000. Over the course of the program few members have reached or come close to reaching these limits. The HIP program monitors members to ensure that members are able to be transferred to another program if they are close to reaching $300,000 in annual limits or $1,000,000 in lifetime limits. This monitoring is to ensure that members are not denied needed services. If a member does reach, or come close to reaching these limits, an attempt is made at determining eligibility for traditional Medicaid. All members who have come within $100,000 of, or reached, the $300,000 annual benefit limit were transferred to ESP, Medicaid or other programs. The number of members that met these criteria in each demonstration year are displayed below. No members have met the $1,000,000 limit.

Table 3: HIP Members at Benefit Limit

Year	Members at $200,000	Members at $300,000	Members at $1,000,000	Total
2008	1		0	**1**
2009	17	2	0	**19**
2010	1	0	0	**1**

[12] Data from Years 1, 2 and 3 annual HIP reports and OMPP Data request 10/12/11.

[13] HIP Year 3 Annual Report, Pg. 29-30.

[14] HIP Year 1 Annual Report, pg. 20.

June, 2011	3	0	0	**0**
Total	**22**	**2**	0	**24**

3.7 POWER Account Contributions

The POWER account, a unique feature of the HIP program, requires members to make upfront contributions to their health care costs. Contributions range from 2% to 5% of enrollee income and can be reduced by payments from an enrollee's employer. Over the course of HIP, there have been a percentage of individuals who do not contribute to their POWER accounts due to the way income is counted. For these members accounts are 100% state funded. The State did not intend for there to be any members who did not contribute to their POWER account, nor was this part of the waiver negotiations. For 2008, approximately 35% of HIP enrollees did not contribute to their POWER account. Over the course of the program this percentage has been decreasing, in December 2010 only 21% of HIP enrollees did not contribute to their POWER account, and in June 2011 20% of members did not contribute to their POWER account. Indiana's waiver renewal request includes modification to the POWER account contributions.

3.8 Disenrollments

Enrollees can disenroll from HIP at any time or be terminated from HIP for failing to pay a POWER account contribution, for failing to complete the redetermination process, or if it is found that the individual no longer meets eligibility requirements. Between 2008 and 2010 a total of 35,323 members left HIP. It was most common for enrollees to leave during the redetermination period approximately 12 months after being enrolled; 57% or 20,015 enrollees left the program within a month of the redetermination period. Of the remaining disenrollments, 6,199 (1,835 in 2008 and 2009 and 4,364 in 2010 and) members were disenrolled because they failed to pay a POWER account contribution. This represents 8% of HIP members ever enrolled in the program. The remaining disenrollments would include pregnant women who are transferred to traditional Medicaid for the duration of their pregnancy, and then may reenter HIP afterwards.[15]

Section 4: Summary of Quality Reports

As required under the STCs, the State has conducted an evaluation of the HIP program and has developed annual reports on the program. Mathematica Policy Research and Milliman have been contracted with to independently evaluate the quality of the HIP program. The 2010 annual report submitted June 2011 discussed in detail the results of Mathematica's monitoring activities. The program shows interesting variations in care seeking behavior between contributors and non-contributors and caretakers and non-caretakers. While all of these groups respond to HIP incentives they have different ways of seeking care which the program continually investigates. A summary of these analyses are included in this waiver renewal application.

[15] Data from Year 3 (2010) Annual Report, submitted June, 2011.

Improves Access To Care:

- The HIP program appears to be meeting its goal to improve access to care for low-income Hoosiers enrolled in the plan. HIP provider networks are adequate. If there are any shortages with particular types of specialty (such as neurosurgeons), plans allow access to out-of-network providers. Data from Mathematica's 2010 survey of HIP members indicate that access to care improves after Hoosiers enroll in the HIP program, they are more likely to receive preventive care and get prescription medications, and they report fewer unmet health care needs. In addition, the proportion reporting the ER as their usual source of care declines dramatically after enrollment in HIP. Mathematica surveyed the use of care in the last six months of new and established HIP members. The table below shows the difference in care utilization between new enrollees and established enrollees. Established enrollees use more primary and preventive services, prescription drugs, are less likely to use the ER and less likely to report the ER as their main source of care.

Table 4: Care Utilization between new enrollees and established enrollees[16]

Care Utilized:	New Enrollees	Established Enrollees
Primary Care	60%	90%
Preventive Care	28%	69%
Prescription drugs	54%	80%
ER	38%	32%
ER as main source of care	30%	9.2%

- Mathematica continues to document that 90 percent of HIP members have a physician visit within 12 months of enrolling.
- A Milliman analysis of HIP enrollee service utilization for the first 18 months of the program compared HIP enrollees to comparable Medicaid and commercial populations. HIP incentives for members to seek preventive care have demonstrated success. Individuals enrolled in HIP had higher preventive care visits than Indiana's HoosierHealthWise (HHW) Medicaid population. The HIP Caretaker population had 445.4 well-care visits per 1,000 enrolles, and the noncaretaker population had 281.8 well-care visits per 1,000 enrollees compared to HHW adults 195.3 visits per 1,000

[16] Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3 (2010), pg. 38. Submitted June, 2011.

enrollees. This analysis indicates that HIP Caretakers seek preventive care more frequently than comparable commercial populations and non-caretakers seek preventive care at rates similar to comparable commercial populations.

Table 5: Preventive Care Utilization (January 2008-June 2009)

Population	Well Care Visit (utilization rate per 1,000)
HHW- Adults	195.2
HIP-Caretakers	445.4
HIP- Non-Caretakers	281.8
Commercial (Adult only) (1)	354.8
Commercial (Adult only) (2)	306.2
Ohio Medicaid Adults	352.7

(1) Age / Gender adjusted to HIP – Caretaker population
(2) Age / Gender adjusted to HIP – Non Caretaker population

- The State monitors member access on a monthly basis including evaluating health plans primary and specialty care networks. Member access is examined on distance from primary and specialty care providers, access to hospital care, and appointment wait times. Mathematica reports that with enrollment in HIP utilization of health care services increased and unmet need declined.

Increases Knowledge of Health Care Spending:

- Data from Mathematica's 2010 survey of HIP members indicate that most survey respondents were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it. Approximately 60% reported knowing the balance of their POWER account and 45% reported checking their account at least monthly, important first steps of cost conscious consumers.[17]
- A 2009 Product Acceptance Research (PAR) telephone survey of HIP members found that six in ten respondents now think differently about how or where they get health care since enrolling in HIP and that one-third have asked the cost of a medical procedure or service before receiving treatment.

[17] Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3.

POWER Account/Consumer Directed Plan Does not Discourage Participants from Seeking Needed Care:

- Mathematica's analysis of utilization shows that members are accessing services and that the POWER account contributions do not discourage participants from seeking needed healthcare. As individuals remain enrolled in HIP, they move away from seeking routine care in the ER and begin seeking care in physicians' offices. Over 12 months of enrollment, on average HIP enrollees show a 14.8% decline in non-emergent ER use and a 25% increase in physician office visits. No evidence was found suggesting that HIPs consumer based structure discourages enrollees from seeking needed care. Additionally, a Mathematica survey of HIP members found that approximately 70% of enrollees indicated that the monthly contribution was just the right amount and something they could afford. Another 7% thought they could afford a monthly contribution that was a little higher than the current amount. In contrast, approximately 8% thought the monthly contribution was far too high.
- At its conception, the HIP program intended to have all members contribute to their POWER account; however, due to the way income is calculated and the lack of a program requirement for a minimum contribution from 2008 to June 2011 between 20% and 35% of enrollees have not been required to contribute to their POWER account. This has led to an opportunity to analyze possible differences in care seeking behavior between contributors and non-contributors. Contributors have lower rates of ER use from the beginning of their enrollment in HIP. Over 12 months of continuous enrollment 35% of contributors visit the ER with 24% visiting the ER at least once for a non-emergent visit. Non-contributors visit the ER more frequently; 57% visited the ER and 34% of non-contributors enrolled for 12 months continuously had a non-emergency ER visit. Non-contributors also experience fewer gains in than contributors in physician office visits, for contributors physician office visits increase by 26% over 12 months of enrollment and for non-contributors it increases by 22%.[18]

Table 6: HIP Members Service Utilization

Over 12 Months of continuous enrollment:	Contributors	Non-Contributors
Any ER Visit	35%	53%
Any Non-Emergency ER Visit	25%	34%
Increase in Physician Office Use	26%	22%

[18] Matematica Data Preview, December 2nd, 2010.

Whether contributing to a POWER account has a direct effect on care seeking behavior remains under investigation. Non-contributors have unique care seeking behavior and are overall more likely to visit an ER than contributors. This may be influenced by their contributor status, however, for all enrollees the HIP program works over the course of enrollment to decrease non-emergency ER use and increase physician office use.[19]

- A Milliman analysis of the first year of Anthem's experience with HIP showed that after adjusting for morbidity differences non-contributors have higher expenditures than contributors. The non-contributor caretaker population had 3.5% increased expenditures over the contributor caretaker population and the non-contributor non-caretaker population had expenditures 13% higher than the non-contributor non-caretaker population.[20]

Currently, HIP is a fully functioning program achieving several of its goals including: improving access to care for low-income Hoosiers; promoting preventive care among most HIP members; providing quality of care; achieving high levels of member satisfaction; and maintaining the program's fiscal soundness. Enrollment patterns continue to indicate that upon entry to the HIP program, most members remained enrolled for a full year or more. Steady enrollment provides opportunities for HIP and the health plans to (1) give members guidance on how to use health care services appropriately and (2) reap the benefits of initiatives that promote the use of preventive care, disease management programs, and case management services. It also means that members have an opportunity to benefit from responding to program incentives.

4.1 Progress on Program Goals

Goal 1: Reducing the number of uninsured low-income Hoosiers

- HIP seeks to reduce the number of uninsured low-income Hoosiers. HIP has been providing an important safety net for its members who would have been uninsured otherwise. Given the expected limited revenue from the State cigarette tax, HIP was not intended to cover all Hoosiers below 200% of FPL. After three years, HIP has served 77,466 Hoosiers.
- Although the overall uninsured rate among low-income working-age Hoosiers did not change between 2008 and 2009, data suggest that uninsured rates among caretakers declined by 4%. At the same time, Medicaid coverage rates among low-income caretakers increased by 7.1%. Those with income below 150% of the FPL experienced declines in their uninsured rates. For example, working-age adults with income between 101% and 150% of FPL saw their uninsured rate decline by 2.6% between 2008 and 2009 while their Medicaid coverage rate increased by 4.3%. The increase in Medicaid coverage rates among low-income adults who are typically not eligible for Medicaid

[19] Data in this paragraph: Mathematica data supplement for the HIP Year 3 Annual Report: December 2, 2010.

[20] Milliman report to HIP Taskforce: August 7th, 2009.

unless they have a disability, suggest that during the economic downturn, Medicaid, including the HIP program, was moderating any increase in uninsured rates.

Goal 2: Reduce barriers and improve statewide access to health care services for low-income Hoosiers

- Plans report that all HIP members, in all health plans, have access to a primary medical provider (PMP) within 30 miles of their homes.
- All plans continue to work on their specialty networks; deficiencies are few, and plan administrators think problems with certain specialties are due to general medical shortage areas, or inadequate numbers of providers for the population as a whole in some regions of Indiana.
- A 2010 Mathematica survey of HIP members suggests that access to care improves after enrollment into HIP. Using respondents who had only enrolled in HIP in the previous month and their access to care while uninsured as the counterfactual against which the success of HIP is judged, the survey data indicate that HIP members are:
    - More likely to have a PMP and more likely to use a doctor's office or clinic as their usual source of care rather than the ER,
    - More likely to receive preventive care, acute care, specialty care, and prescription medications,
    - Less likely to have an unmet need for care.
- All plans are required to submit access reporting annually along with a geo-access map of provider locations. If a plan does not have the necessary access as outlined in the scope of work, the plan must submit the reporting on a monthly basis and outline efforts to increase access. At this time, all plans are meeting the access requirements.

Goal 3: Promote value-based decisions making and personal health responsibility

- HIP uses several financial incentives to encourage members to become thoughtful health care purchasers and active participants in maintaining or improving their health. These incentives begin upon enrollment, when most HIP members are required to contribute to the cost of their care by making monthly payments to their POWER accounts. Findings to date suggest that:
    - As of the end of 2010, nearly four of every five HIP members made a contribution to their POWER account.
    - Utilization differences have been noted between contributors and non-contributors. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members. The non-contributing population in general suffers from higher morbidity, however, the POWER account contributions and the influence of

consumerism cannot be ruled out as factors contributing to this vast difference in utilization.[21]

- Survey data collected by Mathematica in 2010 suggest that the majority of respondents knew key features of the program. For example, 81% of established HIP members were aware of their POWER account, 71% of these believed that they had been given adequate information about the accounts, and 95% knew their monthly contribution amount.
- Over the first two years of the HIP program only 3% of enrollees were disenrolled for failing to pay their POWER account contribution. The disenrollment rate increased over the third year with 4,364 individuals being disenrolled in year three. This was more than twice the number of individuals disenrolled for failure to pay a POWER account contribution for the first two years of the program. At the end of 2010, the disenrollment rate for failure to pay a POWER account contribution over the program history was 8%. Currently, the rate for 2011 seems more consistent with the nonpayment rate for the first two years, out of 43,220 enrollees at the start of 2011, 611 or 1.4% were disenrolled for failure to pay their POWER account through June 2011.
- HIP member eligibility is redetermined annually. Enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85% of HIP enrollees returned redetermination packets on time. For the third year of the demonstration, 2010, 96% of enrollees submitted their redetermination packet on time.

Goal 4: Promote primary prevention

- A large proportion of HIP members obtain primary care services. Given that most HIP members stay enrolled in the program, and only some are cycling on and off, HIP and its health plans should see benefits in promoting the receipt of appropriate preventive care. HIP encourages the use of preventive services by providing first dollar coverage for preventive services. Preventive services up to $500 are not subject to the deductible and members do not have to draw on their POWER account funds. HIP also ties POWER account rollovers, and reductions in future monthly contributions, to the completion of required preventive care.
    - Roughly 90% of HIP members who started eligibility periods in 2008 and 2009 and stayed continuously enrolled for 12 or more months had a physician office visit of any type.[22]

[21] Data from Mathematica Data Enclosure, December 2010.

[22] HIP Year 3 Annual Report, (June 2, 2011).

- Service records for the seven different preventive services the Office of Medicaid Policy and Planning (OMPP) required for full rollovers in 2009 and 2010 indicate that the majority of HIP members received some type of preventive care during their first year of enrollment.
- Analysis of POWER account rollover data shows that for members who had effective coverage dates beginning between January and June 2009 and who were still enrolled in June 2010 during the POWER account rollover process that 80% had received the preventive services required to make them eligible for a full POWER account rollover. Not all members that were eligible for a rollover had remaining POWER account balances but analysis of the rollover process indicates that HIP is encouraging members to seek preventive services.[23]
- Analysis of the first 18 months of HIP shows that members have greater rates of preventive care use than the HHW Medicaid population. For every 1,000 enrollees HIP had 445.4 caretaker preventive visits and 281.8 non caretaker preventive visits while the HHW population had 195.2 preventive visits per 1,000 enrollees. HIP preventive use in caretakers is greater than similar commercially insured populations and the use in non-caretakers is comparable to a similar commercially insured population.[24]
- Considering only services obtained in the first six months after enrollment in the HIP program, encounter claims records indicate that 2009 members obtained preventive care more quickly. For example, within the first six months of enrollment, 41% of young (ages 19-34) female 2008 members had received at least one recommended preventive service. Among 2009 members, 46% of females met this criterion within the first six months of enrollment.[25]
- To promote preventive care, the health plans are pursuing a number of different strategies, including member mailings, newsletters, telephone outreach, and support. The ESP administrator implemented a new care coordination program in 2010.

Goal 5: Prevent chronic disease progression with secondary prevention

- By lowering cost and access barriers to care and activating members to be more engaged patients, HIP aims to slow disease progression among members with chronic conditions. Analyses to date indicate that:

[23] Rollover Report May 2011.

[24] Milliman Data, Presentation to Governor March 23, 2010.

[25] HIP DY 3 (2011) Annual Report.

- Chronic disease is prevalent among members. More than a quarter of those enrolled from January 2008 through June 2010 have been diagnosed with pulmonary, skeletal and connective tissue, cardiovascular, metabolic, or skin diseases. In addition, more than 40% of members have been diagnosed with or treated for psychiatric conditions, including non-chronic depression.
- Non-caretakers were more likely than caretakers to be diagnosed with chronic diseases and are nearly twice as likely to be diagnosed with conditions that are considered to be medium or high cost (24 versus 13 percent), which is consistent with the age differences between these two groups.
- The health plans continued to use several strategies to manage the chronic conditions of their members, including telephone support, disease management programs, and online tools.
- Analysis conducted by Milliman shows that while HIP enrollees experience significant chronic disease burden, that during enrollment in the program use of prescription medication increases and inpatient, outpatient, emergency room usage, and physician services decline. This suggests that HIP members are managing their chronic conditions with prescription medication and, as a result, need fewer direct health services.

Goal 6: Provide appropriate and quality-based health care services

- A critical goal for HIP is to provide appropriate and quality-based health care services and HIP appears to be achieving this goal.
    - Overall satisfaction appears to be high among HIP members. Respondents to the CAHPS surveys administered by the health plans report high levels of satisfaction with their plans—levels that, in most cases, are comparable to or higher than national averages for Medicaid plans. For example, Anthem's plan average composite score for customer service (which includes the percent reporting they always or usually got information they needed from the plan's customer service line, and the percent reporting they always or usually were treated with respect by customer service staff) was 85.1%, a statistically significant difference from the 2009 Quality Compass Medicaid adult average plan score of 76.2%. Likewise, 84.2% of MDwise members were always or usually satisfied with their experiences with receiving care and getting appointments in a reasonable time, a statistically significant difference from the 2009 Quality Compass Medicaid adult average plan score of 80.9%.
    - Mathematica's 2010 survey of HIP members also indicates high levels of satisfaction with the HIP program overall. Approximately 87% of respondents who were new to HIP and 97% or respondents who were

established were "Very Satisfied" or "Somewhat Satisfied" with the HIP Program.

- A Product Acceptance Research Survey in 2009 of HIP members enrolled at least 6 months showed that 94% of HIP enrollees were satisfied with the program and 99% would re-enroll in the program. Seventy-six percent (76%) of individuals surveyed indicated they liked their POWER account, three-fourths of surveyed individuals said they are now more likely to seek preventive care and four in ten indicate that their health is better than it was a year previous.
- Data from the State's Intranet Quorum, the State's issue management system, are consistent with the CAHPS data and do not indicate that members have any serious concerns about the performance of the plans.

Goal 7: Assure State fiscal responsibility and efficient management of the program

- The enabling state legislation requires HIP to be a fiscally sound program. As of the end of calendar year 2010, the HIP program appeared to be achieving this goal. State documentation indicates that:
  - The HIP program continued to meet its budget neutrality goals as of the end of 2010.
  - The 2010 negotiations with the health plans addressed the costs of care.
  - Analysis of the funding mechanisms for HIP finds that state funding was adequate during the program's first three years. Hospitals continued to support the redistribution of DSH funds. Cigarette tax revenues, while declining, were sufficient to meet the program's needs, and the proportion of HIP members contributing to their POWER accounts rose steadily throughout 2010.

4.2 Future Goals of the Demonstration

If the program continues, the State will continue to pursue the goals identified above and will continue study of these areas. Additional study and time to collect additional data will help the State understand the long term impact of HIP. The State intends to continue to investigate the effects of value-based purchasing on enrollee care seeking behavior. The State expects that changes to HIP due to modifications to IC 12-15-44.2 that allow plans to make payments to POWER accounts may be used as disease management incentives. The impact of these contributions on enrollee care seeking behavior will be studied. The State will also study the impact of the required minimum contribution on enrollment and care seeking behavior.

4.3 Health Plan Performance-External Quality Review

In 2010, Burns & Associates, Inc. conducted an external quality review (EQR) of Anthem and MDwise for calendar year 2010. The EQR assessed the performance of the health plans in six areas: (1) cultural competency initiatives, (2) program integrity, (3) accessibility and availability of providers, (4) retrospective authorizations, claim denials, and claim disputes, (5) validation of

performance measures, and (6) validation of performance improvement projects. Plans were assessed independently, and assessments were made for both HIP and HHW programs.

Overall, the EQR found that both plans were fully compliant in the areas assessed. The following outlines some important findings and recommendations:

- Both Anthem and MDwise have undertaken numerous initiatives related to cultural competency, but the EQR recommended that the plans utilize the U.S. Department of Health and Human Service's Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) standards as a tool to ensure that their cultural competency work plans follow these recommended guidelines. In addition, the EQR recommended that Anthem make more materials available in Spanish, and that both plans better use the race and ethnicity data from OMPP in conjunction with claims data to better target health disparities within the HIP population. Anthem has submitted and OMPP has approved additional materials in a Spanish format. All plans have reported that they maintain race and ethnicity data in their respective systems. The Culturally and Linguistically Appropriate Services (CLAS) standards have been implemented with re-bid in 2011. The plans have done internal gap analysis to identify and meet the standards.
- Both plans are following credentialing and recredentialing policies and procedures for HIP, and in early 2010, both plans placed a renewed emphasis on investigating fraud and abuse cases. For example, the plans expanded staff assigned to investigations, and increased the number of investigations they conducted in 2010. They also recommended that since the investigations team is newer at MDwise, that MDwise adopt an ongoing training schedule, similar to what Anthem uses.
- Few clinical issues were disputed in either retroactive authorization or claims disputes, except in ER cases where the 'prudent layperson' rule was cited (and in those cases, the EQR agreed that these denials were made appropriately in cases where they had adequate records to assess this). In addition, most claims denials occurred for administrative reasons, usually because the service was out-of-network or the provider submitted the claim dispute too late (both HIP plans use a "60 day" rule for filing a claim dispute, which complies with the State's administrative rule [405 IAC 1-1.6]). Although the EQR recognized that 'out-of-network' and untimely filing of claims are legitimate reasons for a denial, they suggested that more education, aimed at members about the differences between in- and out-of-network services, and at providers on the timeframe required to dispute claims, is needed. The use of in-network services and the importance of a PMP has been further highlighted throughout the updated member handbooks. Provider education on claims submission is offered by the plans as well as the State's fiscal agent.

- Reviews of the validity of the processes used to report four performance measures in HIP found the data used by the plans appeared to be valid, but the EQR did suggest that improvements could be made. For example, the data reported in Anthem's and MDwise's provider claims dispute reports appeared to be valid, but there were different interpretations between the plans as to what information to provide in the report, so that the results cannot be compared between the plans. OMPP has updated the reporting manual for 2011 to further identify and define the needed information for this report. OMPP has been working with the plans to ensure that the information is comparable across plans.

The EQR report does not suggest the plans have any systematic issues related to their performance. The recommendations and suggestions made to the plans recognized a level of competency at the plans, citing several items as best practices. For example, Anthem's newly hired staff to investigate fraud and abuse was cited as having a very strong process for handling investigations, and among the HHW and HIP plans, "…best illustrated to the EQR how the results from Special Investigations Unit investigations often get fed back as improved processes on the front end to other parts of the organization to prevent fraud and abuse." MDwise was cited for its cultural competency programs, including that MDwise "releases all of its materials in English and Spanish, avoiding the need for Spanish-speaking members to have to specifically request these materials."

After the release of the EQR report in November 2010, the plans took steps to address EQR recommendations regarding provider education. For example, MDwise is providing additional provider education through one-on-one contact and through newsletters. In 2011, Anthem will distribute a new member handbook for the HIP and HHW programs, and the plan also began sending letters to any provider treating an Anthem member who is in the plan's case management or disease management program, to try to improve care coordination.

Section 5: Requested Program Changes

During the 2010 legislative session the Indiana legislature passed IC 12-15-44.2 and made changes to HIP. To this end, the State seeks waiver authority to implement these changes which include:

- Requirement for HIP enrollees to make a minimum contribution of $160 annually, or $13.33 per month. This requirement is limited by income and no enrollee will pay more than 5% of income towards health costs.
- Ability for non-profits not affiliated with a health plan to pay up to 75% of the minimum contribution.
- Ability for health plans to contribute towards members' POWER accounts as incentives for healthy behavior.

- Changes related to the PPACA:
  - HIP as the program to serve the Medicaid Expansion population.
  - Effective in 2014, reduction of the eligibility level to 133% FPL to coincide with PPACA Medicaid eligibility.
  - Authority to the Secretary of the Indiana Family and Social Services Administration to amend the plan and/or benefits in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from the passage of the PPACA.

In addition, the State seeks modification to its budget neutrality agreement based on its experience to date and the changes in the ACA.

5.1 Requested Change: Minimum Contribution

During the original negotiations with the CMS, it was also presumed that all individuals would be making a POWER Account contribution, and the amount of the sliding scale was adjusted to ensure that no individual exceeded the 5% of income limit on cost-sharing, including consideration of CHIP premiums. However, after applying the CMS rules of how income is counted, there were individuals who did not make contributions. Currently, HIP has 21% of participants that are not making contributions to their POWER account and this number has been as high as 35%. During the 2011 session, the Indiana General Assembly passed legislation to correct this issue and instituted a minimum contribution of $160 (IC 12-15-44.2-11).

The sliding scale to calculate member contributions will still be in place, and the legislation limits the minimum contribution to the sliding scale that is in the original waiver. Members will be required to contribute their minimum monthly contribution ($13.33 a month) until they meet the sliding scale limit. The State will also consider all contributions being made by the household including CHIP and Medicare premiums in calculation of the 5% contribution limit. This assures that no individual exceeds the CMS limit of 5% cost-sharing. Once the sliding scale percentage limit is met the State will fund the account. Please see Section 8 on cost sharing for detailed plans to ensure these individuals do not exceed the applicable percentage of income limiting their contributions. For HIP members that do not currently pay a POWER account contribution the State has developed a plan to transition them to contributing enrollees. Please see the transition plan under Section 9 for more detail.

5.2 Requested Change: Not-for-profit Contributions

The original authorizing language for HIP, indicated that only the State, employers, and individuals can make contributions to the POWER account. IC 12-15-44.2 allows not-for-profit organizations to assist with contributions and contribute up to 75% of the enrollee's contribution requirement. Not-for-profits are not allowed to contribute 100% of the member's POWER account contribution because a central tenant of the HIP program is for all individuals to contribute to their care. HIP currently allows employers to contribute up to 50% of an

individual's contribution to the POWER accounts and extending this option to not-for-profit organizations fits with the program's goals to provide affordable consumer directed coverage.

5.3 Requested Change Managed Care Entity Contributions

IC 12-15-44.2 also allows for the HIP contracted MCEs to contribute to the individual's POWER account. Contributions must be linked to a health related incentive, such as completion of a risk assessment, or participation in a smoking cessation program. Again, the original drafters had intended to allow the MCEs to provide health related incentives to individuals through the POWER account. However, the legislation did not specify this and therefore all health related incentives have been paid or given directly to individuals outside the POWER account. Allowing MCEs to pay health incentives to the POWER account aligns with HIP's philosophy and should strengthen the incentive for individuals to invest in health promotion efforts. The new legislation indicates that MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's $1,100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.

5.4 Patient Protection and Affordable Care Act (PPACA) Related Program Changes

5.4.1 Requested Change: Eligibility

IC 12-15-44.2 calls for HIP to be the coverage vehicle for the new Medicaid population authorized under the PPACA. It is the State's intent and desire to enroll individuals under 133% FPL (with 5% income disregard), that are not eligible for Medicaid under another category (such as aged, blind, or disabled populations, pregnant women, children, etc.) into the HIP program under the HIP 1115 demonstration project as of January 2014. Please see the eligibility in Section 6 for more details on Medicaid and HIP eligibility and the transition plan for more details on the process of enrolling these newly eligible individuals in HIP.

To bring HIP in line with PPACA requirements, IC 12-15-44.2 changes HIP eligibility from 200% FPL to 133% FPL (138% with 5% income disregard) effective January 1, 2014. Eligibility would be maintained to 200% through 2013 and begin the transition to 133% FPL in October 2013 at the time of Exchange open enrollment. HIP coverage will begin in January 2014 for non-caretaker adults who enroll during the open enrollment period (see Section 9 for the Transition Plan). This change was instituted to reduce duplication in coverage options as PPACA extends Medicaid eligibility to all individuals under 133% FPL and creates premium tax credits and cost sharing subsidies for individuals between 133% and 200% FPL.

In 2010, 15% (9,015) of HIP members were over 150% FPL and 23% (13,849) are between 100% and 150% FPL; the vast majority of HIP members are under 133% FPL and will not be

affected by this change. For those members who will be transferred from HIP to subsidized commercial products the State has developed a plan to aid HIP enrollees in this transition. Please see the transition plan at Section 9 for more details.

5.4.2 Requested Change: Benefits

The new legislation provides the Secretary of the Indiana Family and Social Services Administration the ability to adjust the HIP benefits to be in line with the new benchmark benefits that are expected to be released by CMS. At this time, we are not requesting any changes to the HIP benefit package, as the benefit requirements for the newly eligible are unknown. As more detail becomes available, the State will work with CMS to assure that the HIP benefit package and/or benefit limits meet the requirements of the benchmark plan guidelines.

5.5 Requested Change: Budget Neutrality

Since HIP extended coverage to non-caretakers that are not currently eligible for Medicaid, the original HIP demonstration project included a budget neutrality agreement. The State based its budget neutrality agreement on diverted Disproportionate Share Hospital (DSH) funding, savings projects, and limited expenditure growth in the HHW population. As a result, CMS agreed to allow the State to cover 34,000 non-caretakers. This number was adjusted in 2009 to 36,500.

The HIP program continues to meet and exceed its budget neutrality requirements and therefore the State requests an adjustment to reflect the current scenario, and also to adjust for the PPACA changes. Due to the savings projects the State implemented in the last three years, the waiver margin has far exceeded projections and requires adjustment. In addition, since non-caretakers are now eligible for Medicaid, the State requests bringing non-caretakers to the "without waiver" side of the equation, starting in 2014. We have prepared the budget neutrality documents to reflect a scenario in 2013, before full implementation of the PPACA, and then 2014-2015 scenario.

The State had a waiver margin of $94 million during the first year of the demonstration which exceeded the projected waiver margin of roughly $28 million for that year. HIP achieved this margin despite enrolling more non-caretakers than had been projected. The large margin resulted from the savings achieved for the HHW populations, 3% to 6% over the projected per member per month (PMPM) rates for this group, and the substantial savings achieved for the HIP caretakers, 16% over the projected per member per month rate.

During the second demonstration year (CY 2009), the State implemented a carve out of pharmacy services to avail the rebates not afforded to Medicaid managed care plans. Representing state and federal dollars, waiver documents estimated a waiver margin of just over $76 million, well above the CMS-approved waiver margin for the year. The most current cost-effectiveness review through December 31, 2010, indicated that the waiver margin for the third year of the demonstration would be substantially higher and just over $364 million state and

federal dollars. This margin is based on falling PMPM rates for HHW groups, which fell between 8% for children and 13% for pregnant women, presumably because of the pharmacy carve out. Projections for the last two years of the demonstration indicate that the State will continue to maintain program costs far exceeding the budget neutrality requirements of the waiver.

Indiana has been highly successful in its additional savings projects; the projects that have been running for three years include (1) third party liability, (2) estate recovery, and (3) fraud. Additionally, the State has begun two new projects to save additional funds, covering incontinence supplies, and hemophilia blood factor. The table below shows savings to date and anticipated savings for the period of the waiver demonstration.

Table 7: Savings Projects[26]

Project	FFY 2007 Baseline	Total Savings To Date	Anticipated Savings Jan. 1st, 2013-Dec. 31st, 2015
Third Party Liability	$19,614,846	$322,048	$11,055,462
Estate Recovery	$9,532,345	$9,040,728	$10,396,837
Fraud and Abuse Collections	$4,295,099	$14,529,037	$16,708,392
Blood Factor Savings		$25,620,766	$24,000,000
Incontinence Supplies		$30,853,523	$36,000,000
TOTAL	$33,442,290	$80,366,102	$98,160,691

Due to the State's great success in these projects as part of the State's renewal application, the State requests the following changes to its budget neutrality agreement:

1) Removal of the additional savings projects from the budget neutrality agreement. The original requirement was for savings of $15 million, or $3 million per year. The State has saved over $80 million to date and expects savings to grow to $98 million between January 1st, 2013 and December 31st, 2015.

2) Moving the non-caretaker population to the without waiver side in 2014. As of January 1, 2014 all individuals under 133% FPL will become eligible for Medicaid, regardless of caretaker status, therefore the State requests that non-caretaker adults be treated similar to the caretaker adults, in the budget neutrality agreement starting in 2014 and not subject to an enrollment cap. In 2013, the State will maintain non-caretakers in the budget neutrality agreement as they are today.

[26] OMPP Data Request: Electronic delivery, 9-30-11.

3) Return of DSH funding. Due to the collective success of the State's management of the HHW program and its savings projects, the State requests that for the period of January 1, 2013 to December 31, 2013 that the DSH dollars be reallocated to the hospitals, as the budget neutrality agreement can be achieved without the DSH diversion. After 2014, with non-caretakers adults on the without waiver side of the budget neutrality agreement the State will have no further need for diversion of DSH dollars. The State requests that DSH dollars be reallocated to hospitals for the entire waiver extension period. The restoration of DSH is imperative to the preserving the Indiana safety net.

Indiana proposes to continue the agreed trend from the original demonstration project for the HHW population through the waiver demonstration period.

Please see the financing attachment for the specifics on the requested changes to the budget neutrality agreement.

Section 6: Eligibility

For the demonstration extension period from January 1, 2013 to December 1, 2013 HIP eligibility will continue to extend to 200% FPL and the State requests no changes to eligibility during the first year of the renewal. Individuals will be HIP eligible if they are between 19 and 64 years of age, not otherwise eligible for Medicaid, and do not have access to employer sponsored insurance. In order to prepare for the PPACA, as directed by IC 12-15-44.2, the State proposes to begin to make eligibility changes to coordinate with the PPACA provisions starting on 10/1/2013. From 1/1/2013 to 9/30/2013 income for new applicants and redeterminations will be calculated using the current income calculation process. The proposed eligibility regulation states that it is considering allowing states to convert to modified adjusted gross income (MAGI) prior to 2014 using an 1115 demonstration. The HIP demonstration would like to take advantage of this opportunity. To coordinate with Exchange open enrollment periods, income for new HIP applicants will be calculated as of 10/1/2013 based on MAGI. IC 12-15-44.2 changes eligibility to 133% FPL as of January 1, 2014, from 10/1/2013 to 12/31/2013 HIP applicants will continue to be eligible to 200% FPL based on MAGI. The regulation also prevents individuals from being excluded for coverage due to a MAGI calculation prior to March 31, 2014. Indiana believes that implementing MAGI for HIP consistent with the open enrollment period increases operational effectiveness; however, to maintain consistency with the proposed regulation Indiana will allow individuals found ineligible, to also be reviewed based on the current eligibility process between October 1, 2013 and March 31, 2014.

The State will prepare to transition HIP members that are above 133% FPL to the Exchange (federal or state). Indiana proposes to schedule a special redetermination period for all HIP enrollees that current eligibility information indicates are over 133% FPL in January, 2014. At this point all enrollees will have their eligibility redetermined based on MAGI; please see the transition plan in Section 9 for more details.

Section 6.1 Populations Ineligible for HIP

Individuals eligible for services under traditional Medicaid are described below. None of these populations will participate in HIP and therefore, none of these populations will have POWER accounts.

Table 8: Current Medicaid Populations Ineligible for HIP

1. Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance
2. Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)
3. Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)
4. Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)
5. Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)
6. Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)
7. Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)
8. Mandatory categorically needy low-income parents eligible under 1931 of the Act
9. Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):
10. Individuals qualifying for Medicaid on the basis of blindness
11. Individuals qualifying for Medicaid on the basis of disability
12. Institutionalized individuals assessed a patient contribution towards the cost of care 1902 (f)
13. Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)
14. Children receiving foster care or adoption assistance under title IV-E of the Act
15. Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)
16. Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)

Section 6.2 Populations Eligible for HIP

The populations described below in Table 9 are the current HIP eligible populations that will be covered through October 2013. Due to PPACA implementation and changes to IC 12-15-44.2 eligibility for HIP will change between 2013 and 2014. Table 10 notes the revised eligibility that will be effective 1/1/2014. Details about how these eligibility changes will be implemented can be found in the transition plan.

Table 9: Healthy Indiana Plan (HIP) Program Eligibility January 1, 2013 to December 31, 2013.

Description	**FPL and/or other qualifying criteria** ***MAGI income calculation begins 10/1/2013 consistent with Exchange open enrollment period**	**Demonstration Eligibility Group**
Demonstration Eligible Groups **January 1, 2013 to December 31, 2013**		
Custodial parents and caretaker relatives currently excluded from the Medicaid State plan who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income up to the AFDC income limit for the particular family size as indicated in the State Plan with resources in excess of $1,000	Parents and Caretakers
Custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income above the AFDC income limit for the particular family size as indicated in the State Plan and up to and including 200% FPL; no resource limit.	Parents and Caretakers
Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers, who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	0% FPL through 200% FPL; no resource limit. At no point in time may the number of individuals exceed 36,500.	Non-caretaker Adults

October 1, 2013 the State will begin to determine eligibility based on MAGI. Non-caretakers who meet the criteria for Medicaid eligibility under the PPACA, but who cannot enroll directly in HIP due to the non-caretaker enrollment cap will be enrolled in HIP coverage effective January 1, 2014 and placed on a waitlist. The requirements that an individual have been uninsured for at least six months and not have access to employer sponsored insurance are removed from the HIP eligibility criteria effective January 1, 2014. Individuals who apply between October 1, 2013 and December 31st, 2013 and are otherwise eligible but ineligible due to these criteria will be granted coverage effective January 1, 2014.

Table 10: Healthy Indiana Plan (HIP) Program Eligibility January 1, 2014 to December 31, 2015

Description	FPL and/or other qualifying criteria	Demonstration Eligibility Group(s)	Consistent with below group(s) prior to January 1, 2014
Demonstration Eligible Groups January 1, 2014 to December 31, 2015			
Adults ages 18 to 64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income under 133% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% disregard, payment of POWER account contribution, no resource limit	Adults (As described in the noticed of proposed rulemaking at 435.119 “the adult group”, parents/caretakers below 23% FPL will not be in HIP.)	Parents and Caretakers, Non-Caretaker Adults

6.3 Eligibility Exclusions

Between January 1, 2013 and December 31, 2013, the State will maintain eligibility as in the current waiver. As such, individuals are excluded from HIP eligibility if:

- They are eligible for comprehensive Medicaid under the State Plan (see Table 8) with the exception of the forthcoming family planning option.
- They are eligible for Medicare.
- They have income in excess of 200% FPL.
- They have access to an employer-sponsored health plan.

- They are currently enrolled in a health insurance program.
- They are excluded from HIP eligibility for 12 months if they fail to pay a POWER account contribution within 60 days; not inclusive of the first POWER account contribution.

To align with the Exchange enrollment period, starting October 1, 2013, the State will begin to use MAGI income calculation to determine HIP eligibility. Between October 1, 2013 and December 31, 2013 HIP applicants disqualified from HIP coverage due to access to employer-sponsored health plans, insurance in the last six months, or enrollment in a health insurance program but otherwise eligible for HIP will be enrolled in HIP coverage effective January 1, 2014. During this same period, non-caretakers who cannot be immediately enrolled due to the enrollment cap will be granted coverage effective January 1, 2014 and placed on the waitlist.

Starting January 1, 2014 the income qualification for HIP will change to be consistent with the requirements in IC 12-15-44.2. Formerly HIP eligible individuals over 133% FPL will be eligible for tax-credits in the Exchange as of January 1, 2014. From January 1, 2014 to December 31, 2015 individuals will be excluded from HIP eligibility if:

- They are eligible for another Medicaid category under the State Plan (see Table 8), with the exception of the forthcoming family planning option.
- They are eligible for Medicare.
- They have MAGI in excess of 133% FPL (138% with 5% disregard).
- They are excluded from HIP eligibility for 12 months if they fail to pay a POWER account contribution within 60 days; not inclusive of the first POWER account contribution.

The State will be submitting a family planning option State Plan Amendment (SPA) per the direction of the Indiana General Assembly. HIP eligibility indicates that a person cannot be eligible for other Medicaid programs. The family planning aid category eligibility criteria will overlap with the HIP eligibility criteria. Therefore, we wish to clarify in the waiver that individuals eligible for the family planning aid category are not ineligible for HIP. The family planning option does not provide comprehensive medical services rather coverage is limited to family planning services and products only. While an applicant may be eligible for both programs, an individual can only participate in one of the programs; HIP or the family planning SPA. Persons participating in HIP have access to comprehensive medical services including family planning, as long as they make their POWER account contributions. An individual may participate in the family planning optional category, and receive family planning services without any contribution. The purpose of this policy is to ensure that barriers are not erected for individuals to elect the coverage that is right for them, whether that be family planning or HIP.

6.4 The Exchange and HIP

At this time, Indiana has not yet determined if it will pursue a state-based Exchange (HIX), or whether it will cede this function to the federal government. If it does pursue an Exchange, individuals that use the HIX and are determined to be eligible for Medicaid under the new Adult group will be allowed to select their HIP plan from the HIX website. HIP eligibles would be provided with quality data that may be comparable to quality data that is provided for the private non-Medicaid health plans, or with other quality data that is required by the Medicaid MCEs. The State will consider allowing individuals that become eligible for a premium tax credit to apply their portion of the remaining POWER account funds toward purchase of their private health plan. The State will consider facilitation of this transfer should it pursue an Exchange.

6.5 Special Redetermination Period

Based on the Indiana Code, the income standards for HIP change January 1, 2014. HIP will initiate a special redetermination period starting January 1, 2014 for all individuals that current eligibility information shows may have income in excess of 133% FPL based on MAGI. Individuals who are determined ineligible for HIP based on income will assisted with screening for eligibility for premium tax credits and in pursuing coverage options through the Exchange (state or federal). Please see the transition plan in Section 9 for more details.

6.6 Enrollment Limit

The original State HIP legislation was explicit that HIP is not an entitlement program, and that the State may not enroll new participants if revenues from the cigarette tax cannot support additional clients. The waiver contemplated achieving this by means of (1) eliminating the disregard for HIP caretakers and (ii) placing an enrollment cap on HIP adults. (See approved STC 21 and 22). While the State has been able to limit enrollment for HIP adults, the maintenance of effort provisions in the ARRA and the PPACA have temporarily prohibited the State from eliminating the disregard for HIP caretakers. For purposes of the MAGI conversion, the State seeks authority to use its state plan income limit, not the limit with the HIP disregards. The State also seeks a waiver of Section 1902(a)(10)(a)(I)(VIII)(i) to permit it to limit enrollment to individuals who would have met the State's income limits for HIP caretakers, without the waiver disregards, in the event that state revenues from the cigarette tax are not sufficient to support the new population.

Section 7: Benefits

The benefits provided by HIP are described below.

HIP offers the following coverage:

1) A basic commercial benefits package once annual medical costs exceed $1,100.
2) A POWER account valued at $1,100 per adult to pay for initial medical costs. The POWER accounts provide incentives for participants to utilize services in a cost-

efficient manner. HIP members make monthly contributions to their POWER accounts depending on their income level and the State funds the remainder of the account.

3) $500 in "first dollar" preventive benefits; these benefits are at no cost to HIP members and will not deplete their POWER account.

Table 11: HIP Benefits

Benefit	**Limits/Inclusions (as applicable)**
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service
Skilled Nursing Facilities	Subject to a 60-day maximum
Outpatient Facility	
Surgery	
Emergency Room	Co-payment for services determined to be non-emergency : $6 for adults 100% FPL to 133% FPL, $3 for adults up to 100% FPL
Urgent Care	
Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Pharmacy and Blood	Generic preference, brands allowed when no generic is available
Professional Services	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient ER Visits	
Office Visits/Consults	
Preventive Services	At least $500 annual first dollar coverage

Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness
Ancillary Services	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available
Home Health	Excludes long term care.
Hospice	
Emergency Transportation	
Durable Medical Equipment/Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).
Lead Screening Services	Under 21 Years of Age
Hearing Aids	
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Subject to the HIP benefit coverage limits
Disease Management Services	

The benefits package for HIP is not benchmark equivalent, as it does not cover dental, or vision services, maternity and non-emergency transportation and includes a $300,000 annual, $1,000,000 lifetime limit. Milliman Inc conducted an analysis comparing HIP to a benchmark benefit plan included as an attachment. Currently, HIP has waivers for the requirement to offer these services and seeks continuation of these waivers.

The new legislation provides the Secretary of the Indiana Family and Social Services Administration the ability to adjust the HIP benefits to be in line with the new benchmark

benefits that are expected to be released by CMS. In this waiver extension application, we are not requesting any changes to the HIP benefit package, as the benefit requirements for the newly eligible are unknown. However, as more information becomes available the State will work with CMS to assure that the HIP benefit package and benefit limits meet the requirements of the benchmark plan guidelines.

Additional guidance is needed around maternity coverage. Currently, when an individual in HIP becomes pregnant they are transferred out of HIP to Medicaid for the duration of their pregnancy and afterwards they can reenroll in HIP. The PPACA lists maternity coverage and newborn care as a required essential benefits in §1302(b)(1)(D). However, when defining those eligible for Medicaid's benchmark coverage plan in §2001(a)(1)(C) the provision excludes those who are pregnant as they are already eligible for Pregnancy Medicaid. Indiana would be willing to include pregnant women in the HIP program to maintain continuity of coverage under one program and to suspend cost sharing requirements for the duration of the pregnancy. The state seeks guidance from CMS on this provision and requests clarification on what programs can enroll pregnant women under 133% FPL with the 5% income.

Section 8: Cost-Sharing

Currently, HIP utilizes two forms of cost sharing. First it requires copayments for non-emergency ER visits. Second it requires individuals to contribute to their POWER accounts. Collectively, the State assures that individuals do not make contributions that exceed 5% of their income. Contributions to POWER accounts are used to pay for health care services received before the deductible is met. POWER account contributions are made on a sliding fee scale basis and are detailed below. Caretakers, consistent with the CMS standard, do not pay more than 5% of their annual income in combined cost sharing (POWER account contributions and ER copays). Caretakers make required POWER account contributions on a sliding scale up to only 4.5% of their income, leaving room for any potential ER copays. Non-caretakers in the current HIP program have up to 5% for their required POWER account contribution and pay a flat $25 for all non-emergency ER visits.

Independent legal analysis of the HIP POWER account contributions—included as an attachment-- indicates that POWER account contributions should not be classified as premiums. Section 1916A of the Social Security Act defines "premium" to include "any enrollment fee or similar charge." The enrollee contribution to the POWER account is not an "enrollment fee;" rather, it is a contribution towards the $1,100 amount in the account. In that way, it is closer to either a deductible or co-insurance (although, unlike those two, it does not relate to a particular service at the time it is paid). Unlike a premium payment, HIP enrollees continue to own their required contributions and in the event of disenrollment from the program any of their remaining contributions are returned to them.

Per CMS rules for HIP caretakers, the total aggregate amount of (1) POWER account contributions, (2) HIP copayments, (3) Medicaid cost sharing requirements, and (4) CHIP cost sharing requirements may not exceed 5% of family income. If a member approaches the cost sharing limit, the health plan verifies the member's cost-sharing documentation, and then notifies the HIP program manager that the member has reached the 5% maximum contribution amount and the date it occurred. The member is not required to pay any further POWER account contributions or ER co-payments for the rest of the 12-month benefit period. Member handbooks were modified in 2009 to clarify that members must maintain their receipts and document their out-of-pocket costs. Members self-monitor and report to the program that they have reached 5% of their income in cost-sharing requirements. Going forward OMPP is working on an automated process that will monitor and verify members spending on POWER account contributions, CHIP premiums and copayments and ensure that these payments do not exceed 5% of income.

8.1 Copayments

Overall, copayments will change to accommodate the new status of non-caretakers as indicated by the PPACA. Since HIP eligibility will align with the PPACA Medicaid expansion group in 2014, those over 133% FPL will no longer be eligible for HIP as of January 1, 2014. Copayments for non-emergency use of the ER are displayed below, after 2014 and PPACA implementation the higher copayment for HIP Adults will be eliminated, as at that time they become a categorically eligible Medicaid group.

Table 12: Waiver Extension Demonstration Year 6 Cost Sharing January 1, 2013 to December 31, 2013 (current HIP waiver)

Population	Non-Emergency ER Use Co-Payment Amount	Power Account Contribution
HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL	$3 per visit	Not more than 2% of income
HIP Caretakers Above 100 % through 150% FPL	$6 per visit	3% to 4% of income
HIP Caretakers Above 150 % through 200% FPL	Lower of 20 percent of the cost of the services provided during the visit, or $25	Not more than 4.5% of income
HIP Adults	$25 per visit	2% to 5% of income based on FPL

Table 13: Waiver Extension Demonstration Year 7 & 8 Cost Sharing January 1, 2014 to December 31, 2015

Population	Non-Emergency ER Use Co-Payment Amount	Power Account Contribution
Adults With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL based on MAGI	$3 per visit	Not more than 2% of income
Adults Above 100 % through 133% FPL based on MAGI	$6 per visit	3% to 4% of income

8.2 POWER Account

The POWER account is an HSA styled account that HIP enrollees use to cover HIP's $1,100 deductible and is the centerpiece of the HIP plan. In the majority of cases both enrollees and the State contribute to the POWER account. Since the beginning of the HIP program between 20% and 35% of POWER accounts have been fully funded by the State as the individuals were not required to pay a POWER Account contribution. The cornerstone of the HIP program is to promote personal responsibility and consumerism in the healthcare system and including non-contributors in the program is contrary to the program's goals; these individuals have no "skin in the game" or incentive to be cost conscious consumers.

The HIP program emphasizes personal responsibility, and the vast majority (92%) of POWER account contributors pay their POWER account contributions on time. HIP enrollees who do not pay any contributions are not expected to have the same degree of personal responsibility as they cannot be disenrolled for failure to pay a contribution. Potentially related to the paying of contributions, these non-contributors have higher non-emergency use of the ER (66.8 visits per 1000 enrollees vs. 34.7 visits per 1,000 enrollees for contributors). The utilization differences between contributors and non-contributors suggest that paying a contribution may impact care seeking behavior.

As discussed previously, HIP has not experienced problems with affordability, and a Mathematica survey of HIP members found of established members that 69% of contributors consider the amount of their POWER account contribution to be 'just right', while 7% indicate they could pay an even greater contribution; 17% indicate the contribution is a little too much and only 5% of HIP established enrollees felt their contribution was far too much.[27] Under HIP, employers are also able to contribute 50% of an individual's required contribution.

During the 2010 legislative session, the Indiana legislature modified IC 12-15-44.2. These modifications include language that requires members to contribute a minimum amount to their

[27] Results from Mathematic 2010 Survey of HIP Members.

POWER account to ensure that all individuals are making contributions and have the appropriate consumer incentives, or "skin in the game." The minimum amount required is an annual contribution of $160 but not more than 2% of income for an enrollee under 100% FPL, 3% of income for and enrollee from 100% to 125% FPL and 4% of income for an enrollee 125% to 150% FPL. The percentage limits in the enabling legislation may prevent very low income adults from making the full minimum contribution. Table 14 indicates the proposed POWER account contributions. Individuals will contribute the required minimum monthly contribution until they meet their income limit and then required contributions for those individuals will be suspended.

Table 14: POWER Account Contributions

Annual Household Income	Minimum POWER Account Contribution	Maximum POWER Account Contribution	Estimated maximum annual/monthly contribution Individual	Estimated maximum annual /monthly contribution Family of 4
All enrollees less than 25% FPL	$160 annually but not more than 2% of annual income	Not more than 2% of income	$54.46/ $13.33	$111.76/ $13.33
All enrollees between 25% and 50% FPL	$160 annually but not more than 2% of income	Not more than 2% of income	$108.90/ $13.33	$223.50/ $18.63
All enrollees between 50% and 75% FPL	$160 annually	Not more than 2% of income	$163.36/ $13.61	$335.26/ $27.94
All enrollees between 75% and 100% percent FPL	$160 annually	Not more than 2% of income	$217.80/ $18.15	$447.00/ $37.25
All enrollees above 100 through 125 percent FPL	$160 annually	Not more than 3% of income.	$408.39/ $34.03	$838.14/ $69.85
All enrollees above 125 through 133 percent FPL	$160 annually	Not more than 4% of income.	$579.35/ $48.28	$1,100/ $91.67
Year 1: January 1, 2013 to 2014 redetermination for below populations on HIP (Below populations will be transitioned to the Exchange in 2014. Please see transition in Section 9 plan for details).				
All enrollees above 133 through 150	$160 annually	Not more than 4% of income.	$653.4/ $54.45	$1,100/ $91.67

percent FPL				
HIP Caretakers above 150 through 200 percent FPL	$160 annually	Not more than 4.5% of income.	N/A	$1,100/ $91.67
HIP Adults above 150 through 200 percent FPL	$160 annually	Not more than 5% of income .	$1,089/ $90.75	N/A

The new legislation also allows not-for-profit entities to make up to 75% of an individual's required contribution. Individuals who receive sponsorship from not-for-profits may pay less than the displayed minimum contributions. Enrollees pay their contributions in equal monthly installments, and are also permitted to pay the entire sum up front.

For those members who do not currently contribute, and who will be required to start contributing on their first redetermination period after January 1, 2013 the State has developed a transition plan described in detail in the next section.

The State will continue to ensure that the POWER account is fully funded from the beginning of individual enrollment and will continue to make contributions to ensure that the deductible can be met if expenses occur at the beginning of the enrollment period. Health plans are required to collect the POWER account contribution from individuals, and individuals will not receive HIP coverage until the first day of the coverage month after the first contribution. This is the current policy and the State requests no changes to this.

Employers may pay 50% of a members required contribution, and not-for-profits may pay 75% of a member's minimum contribution. HIP members that struggle to pay the required minimum contribution will be able to seek employer or non-profit support.

The required minimum contribution of $160 represents 5% of income for an individual making $3200 a year, or 29% FPL. IC 12-15-44.2-11 that contains the language instituting the minimum contribution also contains language that limits maximum contributions. The language from IC 12-15-44.2-11 concerning the minimum contribution requirements and limiting maximum amounts is excerpted below.

> *At least one hundred sixty dollars ($160) per year and not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:*

- *Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level.*
- *Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level.*
- *Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level.*
- *Five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level.*

To track entire family spending on Medicaid services, FSSA is implementing a process to automatically monitor member expenditures and ensure that POWER account contributions, CHIP premium payments, and copayments never exceed 5% of a member's income in line with CMS guidelines. Currently, members must track their own spending and report when they have reached the 5% limit. In the event that a HIP member has exceed 5% of their income but has not met the minimum contribution requirement, the State will suspend the POWER account contribution requirement and ensure the POWER account is fully funded.

Section 9: HIP 1115 Waiver Renewal Transition Plan

OMPP has developed a transition plan for two scenarios, based upon CMS' approval or denial of the HIP 1115 demonstration waiver extension. Should the State's waiver request be denied, the State will begin dismantling the HIP program in June 2012 as described in Plan B. If the waiver is approved, the State will proceed with Plan A.

Plan A: 1115 receives approval for three year extension (2013, 2014 & 2015)

Once the State receives approval from CMS, FSSA will publish a press release and notify all legislators of the waiver approval and the plan for the program going forward.

The changes addressed in this transition plan, which directly affect HIP members, are (1) the reduction of the upper eligibility threshold from 200% FPL to 133% effective January 1, 2014, (2) the requirement of a minimum member POWER account contribution of $160 annually (subject to a 5% income limit) or approximately $13/month, and (3) the option for not-for-profit entities to contribute up to 75% of an individual's monthly POWER account contribution. "Plan

A" addresses the continuation of the waiver and is subdivided to address several populations affected by changes to the 1115 waiver from its original demonstration to the proposed structure in this waiver extension. "Plan A" populations are:

(1) Per IC 12-15-44.2 and the Affordable Care Act, current HIP members between 133% FPL and 200% FPL who will no longer be eligible for HIP coverage in 2014, but will be eligible for an Exchange product.

(2) HIP currently operates a waitlist for approximately 50,000 non-caretaker adults. It is assumed that these individuals will be eligible for enrollment in HIP or an Exchange product and tax subsidy in 2014.

(3) HIP members who currently make no contributions to their HIP POWER accounts ("zero contributors") due to current income counting requirements, but will be required to contribute $160 annually beginning at the start of their renewal period in 2013, as required by State statute.

(4) HIP members under 133% who will maintain HIP eligibility, but may be affected by the $160 annual contribution to the POWER account. These members are currently contributing less than $160 annually.

Trainings will take place with the MCEs: Anthem, MDwise, and MHS as well as provider and other community based organizations. The goal of the trainings is to prepare key stakeholders for the upcoming changes so they may begin planning, as necessary, to best assist HIP members in the transition. Information will be available on FSSA's HIP website (www.HIP.in.gov).

(1) Current HIP members between 133% FPL and 200% FPL

A waiver extension for three years will result in program changes at the end of demonstration year six/renewal year one for current members between 133% FPL and 200% FPL. These individuals will become eligible for Exchange subsidies beginning January 1, 2014 and per Indiana code would no longer be eligible for the HIP, pending CMS approval of the eligibility threshold. The September release of the notice of proposed rulemaking for 42 CFR Parts 431, 433, 435, and 457 *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010* relating to modified adjusted gross income (MAGI), state the following:

"Proposed §435.603(a)(1) and (2) set forth the basis and scope of this section. At proposed §435.603(a)(3), we implement 1902(e)(14)(D)(v) of the Act, as added by section 2002(a) of the Affordable Care Act, which specifies that, in determining ongoing eligibility of individuals enrolled in the Medicaid program as of January 1, 2014, the financial methodologies based on MAGI shall not be applied until the next regularly-scheduled redetermination of eligibility after

December 31, 2013 or March 31,2014, if such individual otherwise would lose eligibility as a result of the shift to MAGI-based methodologies before such date."

As of January 1, 2014 individuals between 133% and 200% FPL will no longer be eligible for HIP eligibility as a result of the HIP change in the eligibility threshold effective on that day, not as a result of a change to MAGI calculation. The following is proposed for individuals between 133% and 200% FPL, who are enrolled in HIP. In keeping with the philosophy that those under 133% FPL will be enrolled in Medicaid and over 133% FPL will be enrolled in a Qualified Health Plan with tax subsidies, the transition plan modifies the redetermination period, such that individuals enroll in a QHP early in 2014. This plan reduces duplication of services offered through multiple programs. The plan for transitioning individuals between 133% and 200% FPL is as follows:

- Prior to July 2012 - Upon waiver extension approval from CMS and no later than July 1, 2012, FSSA will commence putting together a change package for the Indiana Client Eligibility System (ICES) and the claims system, MMIS, to reflect the eligibility threshold change, effective January 1, 2014.
- For individuals enrolled in HIP above 133% FPL under current eligibility standards, a special redetermination period will commence January 1, 2014. Letters will be sent to individuals identified as between 133% and 200% FPL, by October 2013, notifying them of the special redetermination date and of their potential eligibility for coverage through the Exchange. This process aligns the redetermination dates with Exchange enrollment periods.
- October 1, 2013 - A letter regarding changes to the HIP program will be mailed no later than October 2013 to HIP members between 133% and 200% FPL notifying the member that based on the income information the State has, the member may lose HIP eligibility if, at redetermination, their income remains over 133% FPL. The letter will note that a second letter will be mailed by January 1 advising the member to complete the redetermination, how to complete the redetermination, and if found ineligible for HIP but eligible for a tax subsidy, how to enroll in an Exchange product.
- October 1, 2013 - A letter will be sent to all enrollment centers informing them of the changes to the program for individuals between 133% FPL and 200% FPL and how to assist an individual in enrolling in an Exchange product
- The State will develop online training materials for stakeholders to assure there is widespread communication about the changes.
- January 1, 2014 – Redetermination letters will be mailed to individuals above 133% FPL based on MAGI. Individuals will have 60 days to complete their redetermination. If found eligible for HIP, they will remain enrolled in HIP. If

income remains above 133% FPL based on MAGI at redetermination, these individuals will be referred for tax subsidy screening.

- Phone numbers will be provided in the letters for each MCE as well as the Exchange, such that individuals could begin selecting products once they receive their eligibility determination from the State. While no decisions have been made, the State may consider requiring MCEs to offer a comparable product to HIP on the Exchange. Currently, the HIP program requires that MCEs have a commercial product similar to HIP. Information on other available Medicaid products and where to obtain and submit an application will be included in the letter.
- The State will track the progress of the population and may also consider outbound phone calls to members that have not responded.
- For individuals who are found eligible for a tax subsidy, the State will consider directing remaining non-state contribution balances in POWER account contributions to a health savings accounts (HSAs) if the member selects a high-deductible health plan (HDHP), allowing the member to use the non-state balance towards the purchase of an Exchange plan, alternatively the balance will be returned to member as is the current process. The MCEs will hold any balance for six months after reconciliation of the POWER account.

- March 15, 2014 – Termination letters will be sent to HIP members who did not complete their redetermination. These letters will include information on how to enroll in an Exchange product or reapply for HIP.

(2) Individuals currently on the HIP waitlist

The State will take steps necessary to inform individuals on the HIP waitlist that they will be eligible for HIP or an Exchange product in January 2014.

- October 2013 – At the time of the Exchange open enrollment, ICES will issue letters to individuals on the HIP waitlist, in batches, stating that they may be eligible for HIP and that there will no longer be a waitlist for the program. Individuals will need to reapply for the program in order to prove they are still eligible and will need to file this application no later than 45 days from the date of the letter. A phone number will be provided on the letter for individuals to call should they have questions or need assistance. The enrollment broker would be leveraged to assist with any returned letters and subsequent outreach to clients, as noted in the prior section.
    - Case numbers of individuals who are sent application invitation letters will be flagged in ICES so DFR will know who to process as waitlist applicants.
    - In processing eligibility, access to employer sponsored insurance and insurance within the last 6 months will only disqualify individuals through December 31st,

2013. Individuals with these disqualifications but otherwise eligible for HIP will be granted coverage effective January 1, 2014.

- If application is received by DFR by the due date (within 45 days), but without all required documentation to determine eligibility, they will complete the same follow up to obtain verification.
- All applicants over 133% FPL will be screened for tax subsidy eligibility, in coordination the Exchange's open enrollment period. From October 1, 2013 to December 31, 2013 HIP will maintain eligibility levels to 200% FPL; however, tax subsidy screening for the eligible portion of the HIP population will promote streamlined transitions to Exchange coverage for this population.

- Coverage would not begin for non-caretakers determined eligible for HIP until January 1, 2014.

(3) Current members who currently make no contributions to HIP POWER accounts ("zero contributors")

- As soon as waiver approval is received from CMS, FSSA will run a data query to identify all HIP members who currently do not make POWER account contributions. A letter will be sent to these HIP members informing them that they will be required to make POWER account contributions beginning on their first redetermination after January 1, 2013 and that employers may contribute up to 50% and not-for-profit groups may contribute up to 75% of their monthly payment. Individual required contributions will not be phased in until their redetermination period.
- The State will also work with not-for-profit entities and community based organizations to inform them of this recent change.
- The State will meet with the MCEs and other stakeholders to walk staff through the program changes. MCEs will be asked to help coordinate the effort and to be prepared to work with their members to make the transition.
- Changes will be made to FSSA's eligibility and claims management systems (MMIS). It will be particularly important to ensure that no one has a zero contribution and that the default contribution is never zero, but is at least $160 annually or approximately $13/month subject to the income limits present in statute.
- After January 1, 2013 at each individual's appointed redetermination period, the individual will be given information regarding their new POWER account and how to appeal the decision.
- The appeal process for HIP will not change with waiver renewal. Individuals will be required to file an appeal in writing. Once there appeal is received and processed an appeals hearing will be scheduled with Hearings and Appeals.

(4) Those under 133% who will maintain eligibility but may be affected by the changes to the POWER account rules, as their POWER account contribution may increase.

The same process as described in item (3) will be followed, with the difference being that the letters will be tailored to those who may have a change in the amount of their POWER account contribution due to the minimum contribution. The letters will continue to describe the opportunity for not-for-profit participation.

Plan B: 1115 does not receive approval for 3 year extension & the program is dismantled

Should the State not receive approval to continue the 1115 waiver, the State will begin dismantling the HIP program by July 2012. The State will require at least six months of preparation to ensure the transition runs smoothly. The last day of the program will be December 31, 2012. Appropriate steps will be taken to ensure that all members are aware of the closure of the program and of other options that might be available to them.

- Upon denial from CMS:
    - FSSA will publish a press release and notify all State and Federal Indiana legislators of the denial and the subsequent termination of the program.
    - Letters will be sent to all HIP members informing them that due to waiver denial the program will end on December 31, 2012. The letters will note that HIP members may continue to receive coverage for healthcare services through December 31, 2012, should they continue to meet eligibility requirements. The letters will also contain information on other products that could be available to these members upon the closure of the program, such as other Medicaid categories, ICHIA, the PCIP, and commercial insurance.
    - Letters will also go out to individuals on the HIP waitlist notifying them of the closure of the program and the subsequent discontinuance of the waitlist. The waitlist will close and no additional individuals will be placed on the waitlist.
    - The above process will be repeated, to ensure that communication is received.
    - The State will begin negotiations with the three MCEs to amend their contracts to terminate the HIP portion of their combined HHW and HIP contracts.
    - The State will develop a plan to utilize the remaining dollars in the HIP fund.
    - Letters and bulletins will be sent to Medicaid providers, enrollment centers, community based organizations and other key stakeholders of the change informing them of the end of the program.
    - FSSA will commence making necessary changes to its eligibility and claims management system to ensure that members are terminated and that no capitation payments are made to health plans.
- July 2012 - FSSA will stop processing new HIP applications. Any application in process will be denied due to termination of program. Redeterminations will cease, and individuals will be left in the HIP program until the end of the year. DFR staff will be

trained to inform clients that HIP is no longer an option, and applications will be removed from the website and local offices.

- December 2012 – Letters will go out to each HIP member informing them that their coverage was terminated; there will be no appeal rights associated with this termination as the program will have ended. The letters will detail the options that will be available beginning in 2014 via the Exchange, other Medicaid programs, and the commercial market.

Section 10: Evaluation reports

Mathematica developed an evaluation plan for HIP during the HIP initial demonstration period. HIP is meeting its program goals and providing quality care to clients. During the extension period Indiana expects to continue to make some modification to the evaluation design and to focus on new areas of study. Evaluation reports address HIP's progress on program goals in addition to the evaluation questions present in the Special Terms and Conditions (STCs).

Evaluation reports will include evaluation on the below HIP goals:

1. Reduce the number of uninsured low income Hoosiers.
2. Reduce barriers and improve statewide access to health care services for low income Hoosiers.
3. Promote value-based decision making and personal health responsibility.
4. Promote primary prevention.
5. Prevent chronic disease progression with secondary prevention.
6. Provide appropriate quality-based health care services.
7. Assure State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the below STC evaluation questions:

1. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
2. What are the consequences of requiring HIP participants with family income less than 150 percent of the FPL to pay monthly premiums? How many of these participants fail to make their first POWER account contribution? How many of these participants are disenrolled for failure to pay their premiums?
3. To what extent has HIP impacted the uninsurance rate in Indiana?
4. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
5. How many enrollees exhaust their POWER account each year? How many enrollees are able to roll-over a sufficient POWER account balance to reduce their subsequent contributions?

During the waiver extension period the State also intends to investigate if the minimum contribution requirement effectively changes the care seeking behavior on current non-contributors and encourages more cost conscious consumption of health care services.

Section 11: Public Comment Period

This 1115 demonstration extension application follows the proposed rule for 1115 demonstration applications and includes a public comment period. Two public hearings were held for this 1115 waiver renewal, per the requirements under 42 CFR Part 431 and the rules proposed under PART 431 in the September 17, 2010 issue of the Federal Register, 75 FR 56946 – 56961. Both hearings were advertised on the FSSA website, and electronic copies of all documents were posted. The notice below was included in the Indiana Register October 12, 2011 and published in the Indianapolis Star October 14, 2011 and public comment sessions were conducted November 14 and 16, 2011. A copy of this notice is included in Appendix 1.

It is important to note that further public comment on HIP as the vehicle for the Medicaid expansion and for the changes to the program contained within this waiver renewal has taken place during 2011. Two hearings were held where public comment was taken on Senate Bill 461 during the 2011 legislative session. One hearing took place in the Senate Health and Provider Services Committee and another hearing took place in the House Public Health Committee. Additionally, Indiana submitted the requests contained in this waiver as part of a State Plan Amendment (SPA), which CMS unfortunately did not approve. Public comment was taken during the SPA submission process, and a hearing was held on March 23, 2011. The majority of testimony offered at that hearing was regarding the HIP benefit package. Thus, the requests in this HIP 1115 waiver renewal have been thoroughly publically vetted.

11.1 Public Comment Feedback

The two public hearings were held, as scheduled and publicized, on November 14 and November 16 at 1:30pm in the Indiana Government Center conference facilities. There was no testimony given or submitted at the November 14th hearing, and there was one attendee from the Indiana Primary Health Care Association who did not offer comment. The hearing concluded at 1:45pm. At the November 16th hearing, a representative from the Indiana Hospital Association attended and presented comment in favor of the continuance of the Healthy Indiana Plan. Comment was also received from the Indiana Academy of Physicians Assistants on the November 15th, and was included shared for the record at the November 16th hearing. In their written comment, the Indiana Academy of Physicians Assistants asked to have their own billing identifier and increased participation in patient panels. The public comment period was held open for another week, and there was no further testimony was submitted. A court reporter staffed both hearings, and a transcript is available.

A hearing for the previously submitted State Plan Amendment, requested to be effective January 1, 2014, was also held on March 23, 2011 at the Indiana Government Center South, 402 West

Washington Street. The hearing was held as required by 42 CFR 447.76. Seven people testified at the public hearing.

Paul Chase of the Indiana AARP testified that the POWER accounts and the 12 month penalty period for failure to make a POWER account contribution create a barrier to access care. Fran Quigley also testified that the required POWER account contributions create a barrier to accessing healthcare services. Marsha Glass of the United States Lactation Consultants Association urged the inclusion of lactation consultant services to the definition of the preventive services in the benchmark benefit plan. Glenna Shelby testified on behalf of the Indiana Podiatric Medical Association and requested that routine foot care and surgical treatment of hyperkeratosis, metatarsalgia, subluxation of the food and tarsalgia be included in the HIP benefit package. Rachelle Davis on Syncare Indiana also testified that POWER account contributions could prevent individuals from receiving needed care, particularly pregnant women. David Roos of Covering Kids and Families testified in support of Mr. Chase's and Ms. Quigley's testimony on the HIP contribution requirements. Lastly, Pat McGuffey testified on behalf of the Indiana Chiropractic Association that chiropractic services and spinal manipulation should be included in the HIP benefit package.

Section 12: Types of waivers being requested

The State is requesting the below waivers.

Title XIX Waivers

1. **Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B)**
   To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the Hoosier Healthwise program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in Hoosier Healthwise.

2. **Freedom of Choice** **Section 1902(a)(23)**
   To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

3. **Reasonable Promptness** **Section 1902(a)(3)**
   Section 1902(a)(8)
   To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

4. Methods of Administration: Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana not to assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

5. Eligibility Section **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

6. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" in the proposed rule at 435.119, benefits that differ from the benefits offered to the categorically needy group.

7. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults). Indiana will request this waiver for 2013 only. In 2014, asset tests will not be allowed under federal law.

8. Freedom of Choice **Section 1902(a)(23) insofar as it incorporates 42 CFR 438.52(a)**

To the extent necessary to enable Indiana to provide only one choice of plan for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are identified as having certain high-risk conditions.

9. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

10. Prepayment Review **Section 1902(a)(37)(B)**
To the extent necessary to allow Indiana not to ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

11. Cost-Sharing **Section 1916A**
To the extent necessary to enable Indiana to charge require POWER account contributions and copayments up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

12. Dental and Vision Coverage for Certain HIP Caretakers and HIP Adults **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

13. Income Limit **Section 1902(a)(10)(a)(I)(VIII)(i)**
To the extent necessary to enable Indiana to limit enrollment to levels that can be supported by the state's cigarette tax fund.

The current STCs grant HIP the below waivers. The State believes that these waivers are no longer necessary for the HIP program and does not request that their inclusion in the waiver renewal.

1. Statewideness/Uniformity **Section 1902(a)(1)**
To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

2. Disproportionate Share Hospital (DSH) Payments **Section 1902(a)(13)(A) insofar as it incorporates Section 1923(c)(1)**
To the extent necessary to allow Indiana to divert of a portion of DSH payments made to hospitals to cover the demonstration population.

Section 13: Financing Reports

Please see attached financing report prepared by Milliman Inc.

Appendix 1: Notice of Public Hearing

Notice of Public Hearing

Under 42 CFR Part 431 and the rules proposed under PART 431 in the September 17, 2010 issue of the Federal Register, 75 FR 56946 – 56961, notice is hereby given that (1) on November 14, 2011 at 1:30 p.m. in conference rooms 1 and 2, and (2) on November 16, 2011 at 1:30 p.m. in conference room 4, at the Indiana Government Center South, Conference Center, 402 West Washington Street, Indianapolis, Indiana, the Family and Social Services Administration will hold a public hearing on a Medicaid 1115 waiver renewal submission to the Centers for Medicare and Medicaid Services to extend the demonstration for the Healthy Indiana Plan (HIP) for calendar years 2013-2015. The current 1115 waiver is set to expire on December 31, 2012. As a result of the recent changes to Medicaid eligibility initiated by the PPACA and changes authorized by the Indiana General Assembly at I.C. 12-15-44.2, the waiver renewal application includes the authorized modifications to HIP, as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the PPACA Medicaid expansion.

The HIP demonstration project was approved in December 2007, and the program began on January 1, 2008. HIP currently covers non-disabled adults between the ages of 19-65 who meet the following qualifying criteria: income less than 200% of federal poverty level (FPL), no access to employer-sponsored insurance, and no health coverage within the six month period prior to application. The program includes a $1,100 deductible and creates Personal Wellness and Responsibility (POWER) accounts to fund the deductible. Individuals are required to make monthly contributions to the POWER account, and the state funds the remainder of the account to ensure the $1,100 deductible can be met. Minimal copayments of $3, $6 or $25 are charged for non-emergent utilization of the emergency room, per the current HIP program. In 2014, the $25 copayment will be eliminated. HIP is delivered via risk-based managed care and provides a basic commercial benefit package once medical costs exceed $1,1000. Additionally, $500 in first dollar preventive benefits are provided at no cost to the individual.

There are seven program goals in the proposed 1115 waiver application: (1) reduce the number of uninsured low-income Hoosiers, (2) reduce barriers and improve statewide access to health care services for low-income Hoosiers, (3) promote value-based decisions making and personal health responsibility, (4) promote primary prevention, (5) prevent chronic disease progression with secondary prevention, (6) provide appropriate and quality-based health care services, and (7) assure State fiscal responsibility and efficient management of the program. HIP will be evaluated based on progress towards these goals.

HIP currently covers approximately 41,000 individuals. The purpose of this 1115 waiver renewal is to continue HIP for three years, the maximum allowable time period, to use HIP to

cover the individuals newly eligible for Medicaid in 2014, and to make other PPACA-related changes. Changes to the program in this waiver extension, authorized in I.C. 12-15-44.2, include:

- A requirement for enrollees to make a minimum contribution to their POWER Account of $160 annually (but guarantees that individuals will not pay more than 5% of their income towards health costs).
- An allowance for not-for-profits to make up to 75% of a member's required contribution to the POWER Account and authorization for health plans to contribute to the POWER Account to incentivize positive health habits. Currently, employers can make up to 50% of an individual's contribution; this remains in place with the addition of the aforementioned provisions.
- Changes HIP eligibility levels to align with the PPACA expansion limit of 133% of federal poverty level (FPL) starting on January 1, 2014. The current eligibility threshold is 200% FPL.

In the first three years of the 1115 demonstration project, HIP covered 77,466 individuals. Current enrollment for the program is approximately 41,000 individuals. With waiver approval it is anticipated that, beginning in 2014 with the PPACA provisions taking effect, a total of 192,000 parents and 164,000 adults will be enrolled in HIP. Changes to the budget neutrality agreement have been made to reflect the Affordable Care Act changes. Per the memorandum included in this waiver application, "1115 Waiver – Renewal Budget Neutrality Filing," expected expenditures are $2.3B, $3.9B and $4.2B (state and federal) in 2013, 2014 and 2015 respectively. The expected savings, respectively, via the waiver for each of those years, are $150.1M, $487.5M, and $538.0M (state and federal).

The state will identify individuals under 21 years of age who qualify for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and assure that EPSDT services will be provided to those individuals who qualify. In addition, if an individual is recognized as part of a Tribal Nation, the State assures that required services will be provided to qualified individuals. The methods and standards for payment are consistent with the current program: not less than the federal Medicare reimbursement rate for the services provided or at a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

Copies of the HIP waiver renewal documents are now on file at the Indiana Family & Social Services Administration, Office of the General Counsel, 402 W. Washington Street, Room 451, Indianapolis, Indiana 46204 and are open for public inspection. The documents may also be viewed at www.in.gov/activecalendar by selecting the date(s) of the public hearing. Written comments may be sent to the aforementioned address to the attention of Bobbi Nardi or to Barbara.nardi@fssa.in.gov through second hearing on November 16, 2011.

STATE OF INDIANA
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

Timothy N. Brown, M.D.
P.O. Box 861
Crawfordsville, IN 47933

Website: www.in.gov/h41

E-mail: H41@iga.in.gov

COMMITTEES
Public Health: Chair
Education
Family, Children and Human Affairs
Interstate and International Cooperation
Rules and Legislative Procedures

November 17, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

As a member of the Indiana General Assembly and original author of legislation to create the Healthy Indiana Plan (HIP), I write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for HIP for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the Affordable Care Act Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. Our State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Governor Daniels' Administration has been working with CMS over the past year to find a path toward approval of this request, I understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

When we drafted the original legislation to create the program, the POWER account was designed to be the cornerstone of HIP. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution of $160 annually, but individuals will not have to pay more than five percent of income towards health care, per CMS rules.

Congress of the United States

Washington, DC 20510

November 4, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

As Members of the Indiana Congressional Delegation, we write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for the Healthy Indiana Plan (HIP) for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the ACA Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. The State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Indiana officials have been working with CMS over the past year to find a path toward approval of this request, we understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

The cornerstone of HIP is the POWER account. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution of $160 annually, but individuals will not have to pay more than 5% of income towards health care, per CMS rules.

Enrollees have demonstrated a willingness and ability to pay this minimal amount and, as a result, make quality and cost conscious health care decisions. In fact, data provided by the State shows that 97% of HIP members made their required POWER account contributions during the first two years of the program. This fact and additional data cited below make the case that HIP participants are taking greater personal responsibility for their own health, as emphasized by the program:

- During the first 12 months of enrollment non-emergency utilization of the ER by HIP enrollees decreased by 14.8%.
- HIP generic drug utilization is 80% (comparable commercial population: 65%).
- 80% of HIP enrollees complete the preventive services required for POWER account rollover.
- Enrollees are required to complete an annual redetermination. 85% of HIP enrollees submitted their redetermination packets on-time in the first two years of the program. This number rose to 96% in demonstration year three.
- 94% of HIP participants surveyed said they are satisfied with the program, and 99% of respondents indicated that they would re-enroll in the program.

We join the State of Indiana in looking forward to a positive outcome for Hoosiers in need of affordable health care and hope that CMS will approve the State's waiver application as soon as possible.

Sincerely,

/Dick Lugar/

Richard G. Lugar
United States Senator

/Dan Coats/

Dan Coats
United States Senator

/Larry Bucshon/

Larry Bucshon
Member of Congress

/Dan Burton/

Dan Burton
Member of Congress

/Mike Pence/

Mike Pence
Member of Congress

/Todd Rokita/

Todd Rokita
Member of Congress

/Marlin Stutzman/

Marlin Stutzman
Member of Congress

/Todd Young/

Todd Young
Member of Congress

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- 80 percent of HIP enrollees complete the preventive se1vices required for POWER account rollover
- Enrollees are required to complete an annual redetermination. 85 percent of HIP enrollees submitted their redetermination packets on-time in the first two years of the program. This number rose to 96 percent in demonstration year three.
- 94 percent of HIP participants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program.

I am pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. I ask CMS to approve the State's waiver application as soon as possible.

Sincerely,

/Tim N. Brown, M.D. /

Timothy N. Brown, M.D.
State Representative

TB/pd

November 28, 2011

Indiana Hospital Association

1 American Square • Suite 1900
Indianapolis, Indiana 46282-004
317/633-4870 • 317/633-4875 fax
www.ihaconnect.org

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

On behalf of the Indiana Hospital Association (IHA) and our more than 160 member hospitals throughout Indiana, I urge you to grant the State of Indiana's request to renew the 1115 Medicaid waiver for the Healthy Indiana Plan (HIP). IHA supported the legislation that authorized HIP four years ago, and we remain very supportive of this program today. We appreciate this opportunity to support its extension through calendar year 2015.

Without question, HIP provides health care security to thousands of Hoosiers who would otherwise have no source of coverage. What is uniquely important about HIP, however, is the manner in which coverage is made available. Using a thoughtful approach that takes into consideration the financial circumstances of its enrollees, HIP encourages personal initiative and responsibility with respect to healthcare decision-making. This approach directly contributes to the patients' receipt of quality and cost-effective health care services while generating high levels of satisfaction among enrollees with the program.

We would also note with enthusiasm the provision in the State's waiver renewal application that would discontinue the diversion of federal Medicaid disproportionate share (DSH) dollars effective January 1, 2013. Allowing these DSH funds to become available to Indiana's hospitals while preserving HIP will provide needed financial assistance without reducing coverage.

In conclusion, the IHA believes HIP has been a success. Indiana and its citizens will be well served if HIP is soon extended through calendar year 2015.

Sincerely,

/Doug Leonard/

Douglas J. Leonard, FACHE
President

Community Health Network

7330 Shadeland Station, Suite 200
Indianapolis, Indiana 46256
eCommunity.com

November 30, 2011

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

As a participant in Indiana's healthcare delivery system, I write in support of the State of Indiana's 1115 Medicaid waiver renewal request to extend the demonstration for the Healthy Indiana Plan (HIP) in calendar years 2013-2015. HIP is an innovative Indiana program that has had great success in providing low-income Hoosiers with meaningful, consumer -driven healthcare coverage. It would be a great loss to our state if the waiver renewal was not granted for the requested three year period.

The State legislature passed and Governor Mitch Daniels signed SEA 461 earlier this year, which calls for HIP to be the coverage vehicle for the Patient Protection & Affordable Care Act (PPACA) required Medicaid expansion. HIP currently covers approximately 41,000 individuals, and the State's Medicaid actuary anticipates that 350,000- 500,000 more Hoosiers will be eligible for Medicaid in 2014. This program is successful, and we support its continuation.

We join the State of Indiana in looking forward to a positive outcome for this innovative program and the Hoosiers it serves. On behalf of Community Health Network, I urge you to approve the State's requested three year waiver renewal as soon as possible.

Sincerely,

/Anne W. Murphy/

Anne W. Murphy
V.P. Government Relations

December 9, 2011

Franciscan ALLIANCE

FRANCISCAN
ST.ANTHONY HEALTH
Crown Point

FRANCISCAN
ST.ANTHONY HEALTH
Michigan City

FRANCISCAN
ST. ELIZABETH HEALTH
Crawfordsville

FRANCISCAN
ST. ELIZABETH HEALTH
Lafayette Central

FRANCISCAN
ST. ELIZABETH HEALTH
Lafayette East

FRANCISCAN
ST. FRANCIS HEALTH
Beech Grove

FRANCISCAN
ST. FRANCIS HEALTH
Indianapolis

FRANCISCAN
ST. FRANCIS HEALTH
Mooresville

FRANCISCAN
ST. JAMES HEALTH
Chicago Heights

FRANCISCAN
ST. JAMES HEALTH
Olympia Fields

FRANCISCAN
ST. MARGARET HEALTH
Dyer

FRANCISCAN
ST. MARGARET HEALTH
Hammond

FRANCISCAN
PHYSICIANS HOSPITAL, LLC
Munster

FranciscanAlliance.org

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

On behalf of the Franciscan Alliance, a health system with fourteen hospitals in Indiana and Illinois, we write in support of the State of Indiana's request to extend the Healthy Indiana Plan (HIP) Medicaid demonstration waiver. Our system serves a geographic area with a population of 3.7 million people, and the HIP plan has helped many of our patients in need of health coverage. Extending this program through Calendar Year 2015 would be a benefit to thousands of Hoosiers.

The HIP program has experienced strong support among the public, policymakers, and providers for good reason. It is a unique program with a strong focus on promoting wellness that can help provide lessons for the future of healthcare delivery. Surveys indicate that those covered by HIP are extremely pleased with the program.We ask you to allow the renewal of this waiver as requested by the State of Indiana.

Sincerely,

/Kevin D. Leahy/

Kevin D. Leahy
President

CORPORATE OFFICE
PN: 574 256 3935

SHIPPING
1515 Dragoon Trail
Mishawaka, IN 46544

MAILING
P.O. Box 1290
Mishawaka, IN 46546-1290

Indiana University Health

November 17, 2011

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: State of Indiana 1115 Medicaid Waiver Renewal

Dear Administrator Mann:

On behalf of Indiana University Health, Inc., I am writing in support of the State of Indiana's 1115 Medicaid Waiver ("Waiver") renewal request to extend the demonstration for the Healthy Indiana Plan ("HIP") in calendar years 2013-2015.

Indiana University Health ("IU Health") is Indiana's most comprehensive academic medical center and the state's largest safety net provider. Based in Indianapolis, IU Health is affiliated with multiple hospitals and health centers throughout the state of Indiana and maintains a strong partnership with the Indiana University School of Medicine, the nation's second largest medical school and a leader in medical education and research.

IU Health has been a strong proponent of the HIP program since its inception. HIP is an innovative program providing approximately 41,000 Hoosiers access to affordable, consumer-driven healthcare coverage, and its success is well-documented. Data shows that, during the first 12 months of enrollment, non-emergency utilization of ER services by HIP enrollees decreased by 14.8 percent. HIP generic drug utilization is at an impressive 80 percent, comparable to commercial utilization of 65 percent. Moreover, 94 percent of HIP participants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program. It would be a tremendous loss to the people of Indiana if CMS fails to renew the Waiver for the 2013-2015 period.

The success of the HIP program merits its continuation. Consequently, we join the State of Indiana in urging you to approve the State's requested Waiver renewal.

Sincerely,

/Ron Stiver/
Ron Stiver

Cc: Michael Gargano, Secretary, Family Social Services Administration

Ron Stiver
Senior Vice President

Engagement & Public Affairs
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Suite 6100
Indianapolis, IN 46202
T 317.963.7988 F 317.962.2247
iuhealth.org

St.Vincent HEALTH

8425 Harcourt Road
Indianapolis, IN
46260

stvincent.org

St. Vincent
Indianapolis Hospital

St. Joseph
Hospital

Saint John's
Health System

St. Vincent
Carmel Hospital

Peyton Manning
Children's Hospital
at St. Vincent

St. Vincent
Clay Hospital

St. Vincent
Frankfort Hospital

St. Vincent
Heart Center of Indiana

St. Vincent
Jennings Hospital

St. Vincent
Mercy Hospital

St. Vincent
New Hope

St. Vincent
Physician Network

St. Vincent
Randolph Hospital

St. Vincent
Seton Specialty Hospital

St. Vincent
Stress Centers

St. Vincent
Williamsport Hospital

St. Vincent
Women's Hospital

November 29, 2011

Cindy Mann
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

As a participant in Indiana's healthcare delivery system, I write in support of the State of Indiana's 1115 Medicaid waiver renewal request to extend the demonstration for the Healthy Indiana Plan (HIP) in calendar years 2013-2015. HIP is an innovative Indiana program that has had great success in providing low-income Hoosiers with meaningful, consumer-driven healthcare coverage. It would be a great loss to our state if the waiver renewal was not granted for the requested three year period.

The State legislature passed and Governor Mitch Daniels signed SEA 461 earlier this year, which calls for HIP to be the coverage vehicle for the Patient Protection and Affordable Care Act (PPACA) required Medicaid expansion. HIP currently covers approximately 41,000 individuals, and the State's Medicaid actuary anticipates that 350,000-500,000 more Hoosiers will be eligible for Medicaid in 2014. This program is successful and we support its continuation.

We join the State of Indiana in looking forward to a positive outcome for this innovative program and the Hoosiers it serves. On behalf of St. Vincent Health, I urge you to approve the State's requested three year waiver renewal as soon as possible.

Sincerely,

/Vincent C. Caponi/

Vincent C. Caponi
Chief Executive Officer

VCC:km

November 18, 2011

Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Mann:

As a participant in Indiana's health care delivery system, the Indiana Primary Health Care Association (IPHCA) supports the State of Indiana's 1115 Medicaid waiver renewal request to extend the demonstration for the Healthy Indiana Plan (HIP) in calendar years 2013-2015. HIP is an innovative Indiana program that has had great success in providing low-income Hoosiers with meaningful, consumer-driven healthcare coverage. It would be a great loss to our state if the waiver renewal was not granted for the requested three-year period.

The State legislature passed and Governor Mitch Daniels signed SEA 461 earlier this year.SEA 461 calls for HIP to be the coverage vehicle for the Patient Protection & Affordable Care Act (PPACA) required Medicaid expansion. HIP currently covers approximately 41,000 individuals, and the State's Medicaid actuary anticipates that 350,000-500,000 more Hoosiers will be eligible for Medicaid in 2014.This program is successful and we support its continuation.

The Indiana Primary Health Care Association (IPHCA) join the State of Indiana in looking forward to a positive outcome for this innovative program and the Hoosiers it serves.On behalf of IPHCA, I urge you to approve the State's requested three-year waiver renewal as soon as possible.

Sincerely,

/Philip L. Morphew/

Philip L. Morphew
CEO

Indiana Primary Health Care Association, Inc.
429 N. Pennsylvania St., Ste. 333
Indianapolis, IN 46204

P. 317.630.0845
F. 317.630.0849

www.indianapca.org

State of Indiana

Senate

Senator Vi Simpson
Minority Floor Leader
200 West Washington Street
Indianapolis, Indiana 46204
(317) 232-9427
s40@iga.in.gov

Committees:
Rules & Legislative Procedure, RMM
Health & Provider Services
Insurance & Financial Institutions
Joint Rule

November 9, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

As Members of the Indiana General Assembly and original authors of legislation to create the Healthy Indiana Plan (HIP), we write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for HIP for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the Affordable Care Act Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. Our State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Governor Daniels' Administration has been working with CMS over the past year to find a path toward approval of this request, we understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

When we drafted the original legislation to create the program, the POWER account was designed to be the cornerstone of HIP. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution of $160 annually, but individuals will not have to pay more than five percent of income towards health care, per CMS rules.

Enrollees have demonstrated a willingness and ability to pay this minimal amount and, as a result, make quality and cost conscious health care decisions. In fact, data provided by the State shows 97 percent of HIP members made their required POWER account contributions during the first two years of the program. This fact and additional data cited below make the case that HIP participants are taking greater personal responsibility for their own health, as emphasized by the program:

. During the first 12 months of enrollment non-emergency utilization of the ER by HIP enrollees decreased by 14.8 percent
. HIP generic drug utilization is 80 percent (comparable commercial population: 65 percent)
. 80 percent of HIP enrollees complete the preventive services required for POWER account rollover
. Enrollees are required to complete an annual redetermination. 85 percent of HIP enrollees submitted their redetermination packets on-time in the first two years of the program. This number rose to 96 percent in demonstration year three.
. 94 percent of HIP pai1icipants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program.

We are pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. We ask CMS to approve the State's waiver application as soon as possible.

Sincerely,

/Vi Simpson/

Senator Vi Simpson
Minority Floor Leader
State Senate

State of Indiana Senate

Senator Patricia L. Miller
State House
200 West Washington Street
Indianapolis, Indiana 46204-2785
Senate (317) 232-9489
senator.miller@iga.in.gov
www.in.gov/s32

Committees:
Health & Provider Services, Chair
Appropriations
Elections

November 10, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

As a member of the Indiana General Assembly and one of the original authors of legislation to create the Healthy Indiana Plan (HIP), I write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for HIP for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the Affordable Care Act Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. Our State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Governor Daniels' Administration has been working with CMS over the past year to find a path toward approval of this request, I understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

When the original legislation to create the program was drafted, the POWER account was designed to be the cornerstone of HIP. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution

of $160 annually, but individuals will not have to pay more than five percent of income towards health care, per CMS rules.

Enrollees have demonstrated a willingness and ability to pay this minimal amount and, as a result, make quality and cost conscious health care decisions. In fact, data provided by the State shows 97 percent of HIP members made their required POWER account contributions during the first two years of the program. This fact and additional data cited below make the case that HIP participants are taking greater personal responsibility for their own health, as emphasized by the program:

- During the first 12 months of enrollment non-emergency utilization of the ER by HIP enrollees decreased by 14.8 percent
- HIP generic drug utilization is 80 percent (comparable commercial population: 65 percent)
- 80 percent of HIP enrollees complete the preventive services required for POWER account rollover
- Enrollees are required to complete an annual redetermination. 85 percent of HIP enrollees submitted their redetermination packets on-time in the first two years of the program. This number rose to 96 percent in demonstration year three.
- 94 percent of HIP participants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program.

I am pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. I ask CMS to approve the State's waiver application as soon as possible.

Sincerely,

/Pat Miller/

Patricia L. Miller
State Senator

STATE OF INDIANA
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA 46204

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COMMITTEES:
PUBLIC HEALTH, RMM
INSURANCE
STATUTORY COMMITTEE ON INTERSTATE AND INTERNATIONAL COOPERATION

November 9, 2011

The Honorable Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

As a member of the Indiana General Assembly and one of the original authors of legislation to create the Healthy Indiana Plan (HIP), I write in support of the State of Indiana's application for renewal of its 1115 Medicaid Waiver to extend the demonstration for HIP for calendar year 2013-2015. The waiver renewal application includes modifications to HIP to comply with new federal regulations as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the Affordable Care Act Medicaid expansion.

HIP currently covers approximately 41,000 individuals but the State of Indiana's actuary anticipates nearly 500,000 Hoosiers will be newly eligible for Medicaid in 2014. Our State legislature passed and Governor Mitch Daniels signed SEA 461, which calls for HIP to be the coverage vehicle. While Governor Daniels' Administration has been working with CMS over the past year to find a path toward approval of this request, we understand they have met resistance. If CMS does not approve the application in a timely manner, State officials have expressed they will need ample time to notify current enrollees that HIP coverage will be cancelled by December 31, 2012. Conversely, if CMS approves the waiver, the State will need sufficient time to expand and build on HIP's success to cover the enormous Medicaid expansion expected in 2014.

When we drafted the original legislation to create the program, the POWER account was designed to be the cornerstone of HIP. Individuals are required to make monthly contributions to the POWER account based on their ability to pay, and the State funds the remainder. Under the State of Indiana's waiver application, enrollees will be required to make a minimum contribution of $160 annually, but individuals will not have to pay more than five percent of income towards health care, per CMS rules.

Enrollees have demonstrated a willingness and ability to pay this minimal amount and, as a result, make quality and cost conscious health care decisions. In fact, data provided by the State shows 97 percent of HIP members made their required POWER account contributions during the first two years of the program. This fact and additional data cited below make the case that HIP

participants are taking greater personal responsibility for their own health, as emphasized by the program:

- During the first 12 months of enrollment non-emergency utilization of the ER by HIP enrollees decreased by 14.8 percent
- HIP generic drug utilization is 80 percent (comparable commercial population: 65 percent)
- 80 percent of HIP enrollees complete the preventive services required for POWER account rollover
- Enrollees are required to complete an annual redetermination. 85 percent of HIP enrollees submitted their redetermination packets on-time in the first two years of the program. This number rose to 96 percent in demonstration year three.
- 94 percent of HIP participants surveyed said they are satisfied with the program, and 99 percent of respondents indicated they would re-enroll in the program.

I am pleased with the results of the HIP program and join Governor Daniels' Administration in supporting a positive outcome for Hoosiers in need of affordable health care. We ask CMS to approve the State's waiver application as soon as possible.

Respectfully yours,

/Charlie Brown/

Charlie Brown
State Representative
House District 3

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September 10, 2010

MEMORANDUM

To: Anne Murphy

From: Caroline M. Brown and Rachel Grunberger

Re: Covering New Eligibles under HIP

The State of Indiana has asked our opinion as to whether it may use the Healthy Indiana Plan (HIP) as the vehicle for covering the population newly eligible for Medicaid under the Affordable Care Act (ACA). In particular, you have asked whether, in extending HIP to cover ACA's "new eligibles," Indiana can continue to use the Personal Wellness and Responsibility (POWER) Account feature of HIP, which has proven very successful. For the reasons given below, we believe that it can.

In addition, we do not see any barrier to the State moving the HIP program from an 1115 demonstration project to the state plan. However, were the State to continue HIP as a demonstration project, the waiver should be amended to cover newly eligible childless adults as a "hypothetical" Medicaid population for purposes of budget neutrality. This would permit the State to recapture the portion of its disproportionate share hospital (DSH) allotment that is currently diverted to the waiver to satisfy budget neutrality rules.

Background: HIP currently operates under a Section 1115 waiver to provide coverage to certain uninsured adults earning less than 200% of the federal poverty level (FPL).

The adults covered by HIP fall into two categories. The "HIP caretakers" are those who could be covered under Medicaid as caretakers of Medicaid-eligible children. HIP covers adults with incomes or assets above the AFDC income limit set forth in the state plan. (The State plan AFDC income limit is approximately 23% of the FPL and the asset limit is $1,000.) "HIP adults" are uninsured non-custodial parents and childless adults who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200% of the FPL, with no resource limit. For purposes of budget neutrality (a central element of an 1115 waiver), the HIP caretakers are treated as a "hypothetical" population – i.e., one that could be in the state plan but instead is covered under the waiver. The HIP adults are treated as a pure demonstration population. The costs of their coverage cannot exceed the savings that the State has demonstrated elsewhere in the demonstration project. The savings come from a portion of the

DSH allotment that the State does not spend on hospitals, and managed care savings from the Hoosier Healthwise managed care program.

The centerpiece of HIP is the POWER Account, which is modeled on a traditional Health Savings Account (HSA). HIP provides a POWER Account valued at $1,100 per adult to pay for initial medical costs. The POWER Accounts are funded with state, federal, and enrollee contributions. Enrollee contributions are determined on a sliding scale based on the enrollee's income, but do not exceed 5% of an enrollee's gross family income. The State (with federal financial participation) funds the difference between the enrollee's contribution and the $1,100 account value. In calculating the 5% cap, the State takes into account the cost-sharing for all family members (e.g., CHIP premiums for children, POWER account contributions for other HIP participants in the family, Medicare cost-sharing, etc.).

Enrollees use the POWER Accounts to pay for the cost of health care services until the $1,100 threshold is reached. (HIP also provides $500 in "first dollar" preventive benefits at no cost to HIP members; these benefits are exempt from the requirement to use POWER Account funds for the first $1,100 of medical costs.) Once the $1,100 threshold is met, a HIP managed care organization (MCO) or Enhanced Services Plan (for enrollees with identified high-risk conditions) provides coverage for medical services up to an annual maximum amount.

The POWER Account is designed to encourage preventive care, the appropriate utilization of health care services, and personal responsibility. Three years into the program, the State is already seeing evidence that the POWER Account is furthering those goals, with lower emergency room usage in HIP than other programs; over 98% of HIP enrollees making their POWER Account contributions on time; over 76% of HIP enrollees receiving their required preventative services; and over 94% of HIP enrollees reporting satisfaction with the program.

New Eligibles and Benchmark Coverage. Beginning in 2014, the ACA will require States to cover individuals with incomes up to 133% FPL (plus 5% disregard) who are not otherwise eligible under current Medicaid categories. The new eligibles must be provided with a "benchmark" benefit package.

Section 2001 of the ACA mandates that medical assistance provided to the new eligibles must consist of benchmark coverage described in Section 1937(b)(1) of the Social Security Act or benchmark-equivalent coverage described in Section 1937(b)(2) of the Act, unless the individual is exempt from mandatory enrollment in a benchmark benefit plan. Moreover, the benefits package provided to new eligibles must include the "essential health benefits" available under the State Health Insurance Exchanges. *See* ACA §§ 2001, 1302, 10104. The ACA requires the Secretary of the Department of Health and Human Services (Secretary) to define the essential health benefits, which must include at least the following general services:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health benefits and substance use disorder services

- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management; and
- pediatric services including oral and vision care.

ACA §§ 1302, 10104.

Section 1937(b)(2)(A) of the Social Security Act requires benchmark-equivalent plans to cover "items and services" within each of the following categories: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunization. In addition, "[o]ther appropriate preventive services, as designated by the Secretary," must be covered. Social Security Act § 1937(b)(2)(A).

As of July 1, 2010, 42 C.F.R. § 440.335 requires that benchmark-equivalent plans also cover:

- emergency services; and
- family planning services, supplies, and other appropriate preventive services, as designated by the Secretary.

75 Fed. Reg. 23,068, 23,103 (Apr. 30, 2010).

Moreover, although not required by Section 1937 of the Social Security Act, CMS has interpreted certain changes to the statute made by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. 111-3, to require that the following be included:

- Early Periodic Screening, Diagnosis, and Treatment Services
- non-emergency medical transportation.

Id. at 23,076, 23,077.

HIP and Benchmark Coverage. As set forth in the Section 1115 waiver, HIP currently offers the following benefits:

- Inpatient Facility
  - medical/surgical
  - mental health/substance abuse (covered same as any other service)
  - skilled nursing facility (60-day maximum)
- Outpatient Facility
  - surgery
  - emergency room (co-payment for non-emergency services)
  - urgent care
  - physical/occupational/speech therapy (25-visit annual maximum for each type)
  - radiology/pathology

    - pharmacy and blood
    - cardiovascular
- Professional Services
    - inpatient/outpatient surgery
    - inpatient/outpatient/ER visits
    - office visits/consults
    - preventive services (at least $500 annual first dollar coverage)
    - physical/occupational/speech therapy (25-visit annual maximum for each type)
    - cardiovascular
    - radiology/pathology
    - outpatient mental health/substance abuse (covered the same as any other illness)
- Ancillary Services
    - prescription drug (brand name drugs not covered where generic substitute is available)
    - home health, including hospice/home IV therapy (excludes custodial care; includes hospice)
    - ambulance (emergency ambulance transportation only)
    - durable medical equipment/supplies/prosthetics
    - family planning services (excluding abortion or abortifacients; includes contraceptives and sexually transmitted disease testing)
    - lead screening services (ages 19 & 20 only)
    - hearing aides (ages 19 & 20 only)
    - Federally Qualified Health Center and Rural Health Center services (subject to HIP benefit coverage limits)
    - disease management services

The State's Section 1115 demonstration project does not expressly state that HIP is "benchmark" coverage. However, in order for the Secretary to have approved HIP caretakers as a "hypothetical" population that could have received benefits under the state plan, CMS necessarily concluded that the HIP benefits could have been provided under the state plan as a benchmark or benchmark equivalent package. (One of the benchmarks is "Secretary-approved coverage.")

Since the waiver was first approved, however, both Congress and CMS have stipulated that certain benefits, not included in HIP, must be included in a benchmark or benchmark equivalent package. Therefore, if HIP is to be the benchmark package for the new eligibles, we believe that certain benefits will have to be added to the HIP package. Based on the requirements described above, Indiana likely will have to add non-emergency transportation and maternity care services to the HIP benefits package, as well as dental and vision for any HIP participants under age 21. The State also will have to ensure that the package includes any "essential health benefits" defined by the Secretary in future regulations. But given the relative consistency between the existing HIP benefits package and the benefits currently required for benchmark-equivalent plans, we believe Indiana can use the HIP benefits package (with minor modifications) to cover the new eligibles.

HIP and the POWER Account. We believe that Indiana can continue to use the POWER Accounts as the central feature of the HIP program. We have not identified any provision in Title XIX that would prohibit the State from giving enrollees greater control of their health care decisions or encouraging positive health behaviors by requiring use of the POWER account.

A key question is whether enrollees could continue to be required to make contributions to the POWER account once they were a Medicaid population, rather than, as currently, a demonstration population under the waiver. We believe there is a persuasive argument that the contributions could continue at current levels, despite Medicaid's limitations on cost-sharing, including the prohibition against premiums for individuals with family income below 150% of the FPL. *See* 42 C.F.R. §§ 447,71, 447.72. As described below, (1) the POWER account contributions comply with Medicaid's 5% cap on aggregate cost-sharing; and (2) POWER account contributions are not premiums.

POWER Accounts and 5% Aggregate limit. While Medicaid cost-sharing rules vary by income level, service, and eligibility group, in general some cost-sharing is permissible, provided that, in the aggregate, it does not exceed 5% of family income. HIP complies with this requirement. For the "newly eligible" population up to 138% FPL for whom HIP would be a benchmark package, POWER account contributions are capped at 4% of family income.

Under HIP, as it is currently structured, the sliding scale for enrollee contributions to the POWER Account is as follows:

Annual Household Income	**Maximum Power Account Contribution**
All enrollees at or below 100% FPL	No more than 2% of income
All enrollees above 100% through 125% FPL	No more than 3% of income
All enrollees above 125% through 150% FPL	No more than 4% of income
HIP Caretakers above 150% through 200% FPL	No more than 4.5% of income
HIP Adults above 150% through 200% FPL	No more than 5% of income

The regulations require that the cost sharing for *all* individuals in the family be under the 5% cap. It is our understanding that the POWER account contributions are already calculated in this manner and that, for example, the amount that a family pays in CHIP premiums is deducted from the amount that is to be contributed to the POWER account. Therefore, it does not appear that any changes to POWER account contribution levels would have to be made in order to be compliant with Medicaid cost-sharing rules.

However, the regulations also require that the income be measured on a monthly or quarterly period (as specified by the State). To the extent that HIP looks at annual income, it

may need to adjust to a monthly or quarterly calculation, although we believe that is a requirement that the Secretary can waive under Section 1115.

POWER Account Contributions are Not Premiums. In addition to the 5% overall cap, Medicaid regulations include limits on certain types of cost-sharing, including premiums. Premiums may not be charged to individuals with income below 150% of the FPL, which would include all new eligibles. We do not believe an enrollee contribution to the account is a "premium," as that term is understood in both the Medicaid and traditional HSA context, and therefore this limitation should not prevent Indiana from requiring POWER account contributions.

Section 1916A of the Social Security Act defines "premium" to include "any enrollment fee or similar charge." But the enrollee contribution to the POWER Account is not an "enrollment fee;" rather, it is a contribution towards the $1,100 amount in the account. In that way, it is closer to either a deductible or co-insurance (although, unlike those two, it does not relate to a particular service at the time it is paid). There is no prohibition against deductibles or co-insurance (or any cost-sharing other than premiums) for individuals with incomes below 150% of the FPL (except for children, pregnant women, and institutionalized individuals, who would fall into Medicaid eligibility categories other than the new eligibles).

Section 1938 of the Social Security Act, which authorizes state demonstration programs involving "Health Opportunity Accounts" (HOAs), refers to the amounts paid into HOAs as "contributions," not premiums. HOAs are modeled on traditional HSAs, with contributions coming from States, charitable organizations, or other persons or entities that may transfer funds to the State without violating the donation rules of Section 1903(w). There is no indication in Section 1938 or CMS guidance on HOAs that the contributions are in the nature of premiums or enrollment fees. *See* Social Security Act § 1938; *see also* CMS Letter to State Medicaid Directors No. 07-001 (Jan. 10, 2007).

Moreover, in the traditional HSA context, there is a clear distinction between use of funds contributed to an HSA and payment of health insurance premiums. *See* Internal Revenue Service, *Publication 969, Health Savings Accounts and Other Tax Favored Health Plans* (2009), *available at* http://www.irs.gov/publications/p969/ar02.html (describing restrictions on the use of HSA funds to pay insurance premiums); *see also* U.S. Dep't of Treasury, *HSA Frequently Asked Questions*, available at http://www.ustreas.gov/offices/public-affairs/hsa/faq_using.shtml (stating that an individual can only use an HSA to pay health insurance premiums if the person is collecting federal or state unemployment benefits, or if the individual has COBRA continuation coverage through a former employer). The POWER Account is modeled on the traditional HSA and, accordingly, the contributions to a the POWER Account should be viewed as distinct from premiums or enrollment fees.

In addition, Congress has recognized, in the context of HOAs, that programs designed around HSA-like accounts have the capacity to yield tremendous benefits, such as creating patient awareness of the high cost of medical care, providing incentives to patients to seek preventive care services, reducing inappropriate use of health care services, and enabling patients to take responsibility for health outcomes. *See* Social Security Act § 1938. And, in the HOA context, States have significant flexibility with respect to cost sharing. *See id.* (providing that the

requirements of Sections 1916 and 1916A do not apply to HOA demonstration programs). Taking the position that contributions to the POWER Account are premiums -- and therefore are prohibited for individuals below 150% FPL -- would be inconsistent with these policy objectives.

Finally, we note that the HIP demonstration project documents include a statement that among the Title XIX requirements "not applicable" to HIP is Section 1916(a)(1), "to the extent necessary to enable Indiana to charge premiums for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP adults)." Because the enrollment fee is never referred to as a "premium" in the terms and conditions, we believe this can be interpreted as a determination, by CMS, that the POWER account contributions are not premiums and therefore the prohibition on premiums is "not applicable" to the HIP program.

HIP and Retroactive Eligibility. Like many 1115 waivers, HIP has a waiver of the provision requiring Medicaid coverage for the three-months prior to application, if the individual met eligibility requirements. Nothing in ACA would prevent continued waiver of that provision. However, HIP would have to continue as an 1115 waiver and not under the state plan.

HIP and Budget Neutrality. Even if the State continues HIP under the 1115 demonstration project authority (rather than under the state plan), once the HIP adults are Medicaid eligible, they can (like the HIP caretakers) be treated as a hypothetical population that "pays for itself" under budget neutrality principles (*i.e.*, counted as expenditures both under the waiver and in the without waiver baseline). This means that there is no longer a need to "pay" for this population with diverted DSH funds or Hoosier Healthwise savings.

One option that the State might want to consider is seeking an amendment to the waiver under which HIP adults are treated as Medicaid eligibles because the State could, hypothetically, become an "early expansion" State. ACA permits States to expand coverage to the new eligibles before 2014. As a practical matter, the State would not be in a position to enroll all the newly eligible HIP adults at the same time, but would have to control enrollment in order to permit provider capacity to grow and to provide sufficient time for orderly growth. This appears to have been envisioned by ACA, which permits States to phase in enrollment by income level. The build up of enrollment of HIP adults, as a hypothetical population, would let the State "hit the ground running" once the new eligibility criteria become mandatory on January 1, 2014.

Please let us know if you have questions about any of the foregoing.

1. Number of people affected by enhanced coverage, benefits or retained enrollment.
   OMPP Response: It is assumed that the current 42,000 individuals enrolled under the Healthy Indiana Plan 1115 waiver would continue coverage under a waiver extension. Milliman, Inc. conducted an analysis on behalf of the Medicaid program, and 302,000-413,000 additional adults may be eligible for Medicaid in 2014.

2. Number of potential new eligible people.
   OMPP Response: Per an assessment conducted by Milliman, Inc. 302,000-413,000 adults could be eligible for Medicaid under the Affordable Care Act (§1902(a)(10)(A)(i)(VIII)).

3. Does this plan provide eligibility simplification?
   OMPP response: Not at this time, however, review of the rules for Modified Gross Adjusted Income may provide more clarity.

4. Will provider payments increase?
   OMPP Response: No. Provider payments will maintain their current Medicare reimbursement rate and structure in the State's current 1115 waiver. For CMS defined E&M codes, we will increase as directed.

5. Does this plan provide delivery system innovation?
   OMPP Response: HIP, as per the current 1115 waiver, provides delivery system innovation in that it encourages personal responsibility and cost conscious consumption of healthcare services. HIP places a unique emphasis on the receiving of preventive care services and healthy behaviors.

6. Has your office received any expression of interest in this amendment from the Governor's office, Congressional offices, or other outside parties?
   OMPP Response: The Office has received expressions of interest from outside parties, including the Office of the Governor, members of the Indiana General Assembly and Indiana's Congressional delegation members Representative Mike Pence, Representative Dan Burton, Representative Larry Bucshon, Representative Todd Rokita, Representative Marlin Stutzman and Representative Todd Young. The State met with a variety of external stakeholders, and the amendment was by and large supported by these groups.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

July 31, 2012

Michael Gargano
Secretary
Indiana Family and Social Services Administration
402 W. Washington St.
P.O. Box 7083
Indianapolis, IN 46207-7083

Dear Mr. Gargano:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has reviewed Indiana's December 27, 2011, request to extend its section 1115 Healthy Indiana Plan (HIP) Demonstration, and make the Demonstration, with some modifications, the coverage vehicle for the Medicaid newly eligible population effective January 1, 2014. In addition, you requested authority to establish, prior to 2014, a minimum annual POWER account contribution for all Demonstration participants as well as authority for non-profits to contribute up to 75 percent of an individual's POWER account contribution.

We share the State's goal of maintaining coverage for the approximately 42,000 parents and childless adults currently enrolled in the HIP program, and are prepared to approve a one-year extension of the Demonstration through December 31, 2013. To further support the goal of promoting coverage, we are prepared, as part of this extension, to approve the State's request to provide authority for non-profits to contribute up to 75 percent of an individual's POWER account contribution. We are not, at this time, approving the minimum annual POWER account contributions.

The one year extension will allow Indiana to provide continued coverage under its Demonstration while allowing time for the state and CMS to continue our discussions as Indiana considers its options for 2014. Extending the Demonstration through the end of 2013 is also consistent with our approach to other Demonstrations, whose authority to cover low-income adults sunsets in 2013 in anticipation of the new coverage options available in 2014. The extension will also allow you to provide us with the most recent evaluation of the Demonstration that was due to be completed in May 2012 as part of the annual report.

Please let us know how you want to proceed. My staff is ready to finalize the Demonstration's Special Terms and Conditions and authorities as well as the budget neutrality agreement to allow for the one-year extension. We also would be happy to meet with you to discuss these issues, as you recently requested in your July 25th letter. We look forward to continuing to work in

partnership with Indiana to ensure ongoing coverage for those enrolled in the HIP Demonstration. If you have additional questions regarding this letter, please let me know, or contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group at (410) 786-5647.

Sincerely,

/Cindy Mann/

Cindy Mann
Director

cc: Alan Freund, Acting ARA, Chicago Regional Office
Victoria Wachino, CMCS
Patricia Cassanova, Medicaid Director, Indiana Family and Social Services Administration