Member Handbook

Indiana PathWays for Aging

Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Anthem | PathWays for Aging

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To get this handbook in other formats, such as Braille, large print or audio CD, call Member Services at **833-412-4405 (TTY 711)** Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

You can learn more about Anthem on our website at **anthem.com/inmedicaid**.

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I'm Dr. Kimberly Roop, plan president at Anthem. I'm a physician and part of a team of dedicated doctors, nurses, and other Anthem staff who are here to improve your health and the health of our communities.

Anthem works with the State of Indiana to bring you the **Indiana PathWays for Aging** healthcare program. We've been honored to serve Hoosier Medicaid members since 2007. Now that you're a part of the Anthem family, we are here to help you meet your personal health goals. This member handbook will tell you how to use your new health plan and make the most of your benefits.

Inside, you will find:

- How your Anthem health plan works.
- Services that are part of your plan benefits.
- Programs to help keep you well.
- Helpful phone numbers.
- Help if you don't understand something or have a problem.
- Your member rights and responsibilities.

We're committed to helping you get the care you need and deserve. Now that you're an Anthem member, **here are a few things we encourage you to do right away**:

- Activate your account on the Sydney Health mobile app or at **anthem.com/inmedicaid**.
- Select a doctor and make an appointment for a checkup.
- Complete the Health Needs Screening with your care coordinator.

Also, remember to keep your member ID card with you at all times. Show it every time you need healthcare services.

Thank you again for choosing us as your healthcare plan!

Sincerely,

Kimberly Roop, MD, MBA
Plan President

Indiana PathWays for Aging Member Handbook

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Welcome to Indiana PathWays for Aging

Indiana PathWays for Aging (PathWays) is an Indiana health coverage program for Hoosiers aged 60 and older who are eligible for Medicaid. Research shows that most older adults — 75 percent or more — want to age at home and in their communities. Indiana PathWays for Aging makes it possible for Hoosiers to age their own way. A nursing home might be the right choice for some individuals. However, PathWays offers more choices that allow individuals to get nursing facility level of care at home or in a community setting, while living independently. This manual will provide you with information on how Anthem works and important resources.

Contact Us

Mailing address:

Anthem Blue Cross and Blue Shield
Mailstop IN0205 C442
220 Virginia Ave.
Indianapolis, IN 46209-6227

Online: **anthem.com/inmedicaid**

Hours of Operation

Anthem is open for business Monday through Friday, 8 a.m. to 8 p.m. Eastern time. Anthem is closed on New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving Day and the day after Thanksgiving, and Christmas Day.

Technology at your service

Anthem offers online tools to make it easier for you to access care and services. With our secure member website and mobile app, you can manage your healthcare with a few clicks. Just go to our website at **anthem.com/inmedicaid** to set up your secure account. Once you're registered, you can:

- Choose or change doctors.
- Order a new ID card.
- Look at the status of claims.
- See your care plan.
- Contact Member Services.
- Have messages/communications sent to your account.

It's easy, and you'll be able to get things done without the wait.

Working With Anthem

Welcome to your Anthem Blue Cross and Blue Shield Indiana PathWays for Aging (PathWays) member handbook. **Read this quick guide to find out about:**

- Your benefits.
- Important phone numbers.
- Choosing a primary medical provider (PMP).
- Pharmacy services.
- Ways to good health.

Important phone numbers

Service area	Phone number	Information
Member Services	**833-412-4405 (TTY 711)**	Hours: Monday through Friday from 8 a.m. to 8 p.m. Eastern time. Call for questions about: • Your Anthem health plan coverage • Behavioral health • Your care or service coordinator • Pharmacy benefits • Utilization management
24/7 NurseLine	**833-412-4405 (TTY 711)**	A nurse is available 24 hours a day, 7 days a week.
Behavioral Health Crisis Hotline	**844-721-1304 (TTY 711)**	Speak to a licensed behavioral health professional when you are going through a mental health or substance use crisis. You can call 24 hours a day, 7 days a week.
988 Suicide and Crisis Hotline	**988**	Providing 24/7, free, and confidential support for those experiencing a suicidal crisis or emotional distress.
Utilization Management (UM)	**833-412-4405 (TTY 711)**	Hours: Monday through Friday, 8 a.m. to 5 p.m. Eastern time. Call for questions about UM or an approval request. You may ask for an interpreter. If after hours, you can leave a private message. Staff will

Service area	Phone number	Information
		return your call the next business day or at a different time upon request. Staff will tell you their name, title, and organization when making or returning calls.
Transportation Services	**844-772-6632 (TTY 888-238-9816)**	Call to set up transportation to your doctor appointments. Calls for routine reservations are accepted Monday through Friday from 8 a.m. to 8 p.m. Eastern time. Calls for urgent and same-day reservations are accepted 24/7. Calls for cancellations, status updates, and hospital discharges are accepted 24/7. Please see Anthem for more information regarding transportation services available to you on page 36.
Relay Indiana	**800-743-3333 (TTY 711)**	For members with hearing or speech loss, a trained person will help them speak to someone using a standard phone.
Superior Vision Member Services	**866-866-5641 (TTY 800-428-4833)**	Call for information about your vision benefits and to find a provider in your area.
Indiana Family and Social Services Administration (FSSA)	**800-403-0864**	Call to report any information changes, such as a change in your telephone number, family size, address, and income.
Dental Member Services	**888-291-3762 (TTY 800-466-7566)**	Find a dentist in your area or learn more about dental benefits available to you.
Quit Now Indiana	**800-784-8669**	Free, phone-based service to help smokers quit.
State Ombudsman Program	**800-622-4484**	Call this number if you think or feel that you may be at

Service area	Phone number	Information
		risk of abuse, self-neglect and/or exploitation, have issues with Anthem, and/or in need of adult protective services (APS).
Enrollment Broker	**87-PATHWAYS-4 (877-284-9294)**	Call for enrollment questions or choice counseling.
Translation or alternative format services	**833-412-4405 (TTY 711)**	Call to request this handbook in other formats such as Braille, large print, or audio CD. We can translate information free of charge.

How and When to Report Changes

Anthem keeps your information on file for many reasons. It is important that your information is up to date. Whenever you have a change of information, you need to report it to Anthem. Insome cases, you will also need to report your changes to the Division of Family Resources (DFR).

Reporting Changes to Anthem

Anthem should be updated on your contact information. This can be things like:

- Name
- Address
- Phone number
- Change in insurance (such as getting another insurance plan)

Reporting Changes to the Division of Family Resources (DFR)

The Division of Family Resources should be updated on all of your general information. If you have a change in any of these, you must let the DFR know. You can call **800-403-0864** to report your changes to the DFR or go online at **fssabenefits.in.gov**.

- Name
- Address
- Phone number
- Change in family size
- Change in income

Part 1 – All About Your PathWays Plan

Member Identification
As a PathWays member, you will receive a member ID card that includes your 12-digit member ID number. Your member ID card is very important. Remember to keep your member ID card with you at all times. Show it every time you need healthcare services. Remember these three things for your member ID:

- **Keep your member ID card with you at all times.** Your ID card is very important. It shows you are an Anthem member and have the right to get healthcare.
- **Show this ID card every time you need healthcare services.** Only you can get healthcare services with your ID card. Don't let anyone else use your card.
- **If you lose your card, ask for a replacement card.** Log in at **anthem.com/inmedicaid**. Or you can call Member Services at **833-412-4405 (TTY 711)**.

Plan Selection Period/Changing Health Plans
With PathWays, you must remain in your chosen health plan for a one-year period if you remain eligible. You may only change your Anthem health plan during certain times of the year or for certain reasons.

Individuals will have the chance to change a health plan:

1) Within 60 days of starting coverage,
2) At any time, your Medicare and Medicaid plans are no longer aligned (e.g., you disenroll from one Medicare Advantage plan to another during the quarterly Special Enrollment Period [SEP]),
3) Once per calendar year for any reason,
4) At any time using the just cause process. See the section, *Grievances and Appeals*, "Just cause reasons"; and
5) Additionally, during a plan selection period, which will be aligned with the Medicare open enrollment window (mid-October to mid-December) to be effective the following calendar year.

Coordination of Medicare and Medicaid Services

Anthem will help arrange all your Medicare and Medicaid services, including:

- Care for you, regardless of your Medicare service delivery system or Medicare plan benefit package. This includes:
    - Traditional Medicare
    - Unaligned Medicare Advantage plans
    - Chronic Conditions Special Needs Plans (C-SNPs)
    - Institutional Special Needs Plans (I-SNPs)
    - Medicare Advantage/Dual Special Needs Plans (D-SNPs)

Anthem will help ensure:

- Services covered and provided in PathWays are delivered without charge to you.

- You are dually eligible for Medicare and Medicaid services.
- You receive medically needed Medicaid covered services that may not be covered by Medicare.

We will work with Medicare payers, Medicare Advantage plans, and Medicare providers as needed to arrange the care and benefits you receive. We also will work with all relevant state and social service agencies and community-based organizations (CBOs) as needed to better identify and address your medical and social needs.

Medicare Election
A person can be eligible for both Medicaid and Medicare and receive benefits from both programs at the same time. A Dual Eligible Special Needs Plan (D-SNP) is a type of health insurance plan for people who have both Medicaid and Medicare. If that's you, you're "dual-eligible."

- A prospective member who is eligible for Medicare must:
  - Enroll in and remain enrolled in all parts of Medicare for which the prospective member is eligible (Medicare Part A, Part B, and/or Part D); or
  - Obtain all Medicare Part A, Part B, and Part D benefits, if eligible.
- If a member becomes Medicare-eligible after enrollment, the member must enroll in all parts of Medicare for which the member is eligible.
- When you become eligible for Medicare, you will automatically be enrolled in Anthem's D-SNP. This helps your Medicare and Medicaid benefits work together. If you don't want to enroll in Anthem's D-SNP, you may choose to get your Medicare coverage through another plan or through Original Medicare. Information about Medicare and Anthem's D-SNP will be sent to you before you are eligible for Medicare so you can make a choice on your Medicare benefits.

You can get information on D-SNPs by contacting the State Health Insurance Assistance Program (SHIP) at **800-452-4800** to speak to a counselor. SHIP is a free counseling program for people with Medicare. You can get one-on-one help in person, on the phone, or virtually.

Care Coordination and Service Coordination

Anthem wants to make sure all PathWays members can live, learn, work, and enjoy life in the setting of their choice. For most members, that means remaining in their homes and in their communities. Other members may prefer to reside in a long-term care or nursing facility. We'll work with you, your doctors, and other agencies involved in your care to help coordinate the services you need — including services delivered in your home or community — to live independently for as long as possible. This is called care and service coordination.

A care coordinator helps you manage your physical and mental health needs. Your care coordinator will contact you to create a specific plan of care based on your preferences and needs. This is called the individualized care plan (ICP). Your ICP will include specific objectives, goals, and action steps to meet your identified needs. Your care coordinator will check in on you either monthly or quarterly, or more often depending on your needs. They can also help answer questions about your healthcare and help you with your providers. Your care coordinator is your primary contact person for your PathWays plan.

A service coordinator helps PathWays members who are receiving long-term services and supports (LTSS). They will be your primary contact person for questions about your long-term care services. They will check in on you monthly, or more often if needed. Your service coordinator will work with you to make a Service Plan, or a support plan to help you access long-term care services, as well as medical, social, housing, educational, and other supports. Your Service Plan will help you:

- Build or maintain relationships with your families and friends.
- Live as independently as possible.
- Engage in productive activities, such as volunteerism or employment.
- Participate in community life.

To help you make your Service Plan, your service coordinator will complete a health assessment with you. A health assessment is a set of questions that ask about your personal behaviors, life-changing events, health goals and priorities, service coordination, and overall health. Your Service Plan will include the home- and community-based services (HCBS) that best meet your long-term care needs. Not everyone in PathWays will need a service plan. Home- and community-based services are provided wherever you call home to help you remain safe and have the best quality of life. Examples of home- and community-based services might be home-delivered meals or an aide to come help you take a shower (Attendant Care).

Whether you wish to stay in your home or go to a long-term care or nursing facility, you can contact your care or service coordinator to share your concerns. Your care and/or service coordinator will:

- Listen to you and take the time to understand your specific needs.
- Help you make an individualized care plan and service plan to reach your identified goals.
- Connect you to the services, tools, support, and community resources that can help you improve your quality of life.
- Provide health information that can help you make informed choices.
- Help you coordinate care with your providers.

Home- and community-based services (HCBS)
Home- and community-based services (HCBS) are available to eligible members who need long term-term care. These members choose to remain in their home instead of living in a long-term care institution, such as a nursing facility. HCBS help a person to be as independent as possible and live in the least restrictive environment possible while maintaining safety in the community. Not all PathWays members are eligible for HCBS. They are only available for members who have a nursing facility level of care (NFLOC) determination. For more information, contact your care coordinator.

Service	Service Definition
Adult Day Service	Adult Day Service (ADS) are group programs in the community that provide structured, social experiences outside of the home. The main goal of ADS is to offer health, social, fun activities, supervision, support services, and personal care. ADS also gives meals like breakfast, lunch, and healthy snacks as needed. Your service coordinator will help you determine whether ADS is right for you.
Adult Family Care	In Adult Family Care (AFC), a member lives with a caregiver who isn't related to them and up to three (3) other participants who have physical and/or cognitive disabilities. Members live in a home that is owned, rented, or managed by the AFC provider, that is safe and free of health hazards, has privacy and allows them to make their living area their own, and offers around-the-clock services such as medication oversight (as allowed by State law) and help with activities of daily living.
Assisted Living	Assisted living service is a type of help given in a group living setting. It comes with personal care and services, home and community assistance, chores, and companion services. It also offers therapeutic social and recreational activities, non-emergency non-medical transportation, and around-the-clock services such as medication oversight (as allowed by State law) and attendant care.
Attendant Care	Attendant Care services (ATTC) are direct, hands-on care services for members who need nursing facility level of care at home including help with activities of daily living. Services include activities such as bathing, hair care, toileting, preparing meals, bill paying, and non-medical transportation. The member may be the employer for participant directed ATTC or choose a representative to be the employer on their behalf.
Care Management	Care Management is a process of understanding a member's needs through person-centered assessment and planning. This includes finding out a member's strengths, needs, goals,

Service	Service Definition
	and likes to help members develop an individualized care plan (ICP) and/or service plan that is right for them. This plan may include community resources as well as paid services.
Structured Family Care	In Structured Family Caregiving, the member lives with a main caregiver who provides daily care and support based on the member's needs. The main caregiver may or may not be a family member but must live with the member in the same home. Caregivers must be qualified to meet all Federal and State regulatory guidelines. They can get caregiver training to provide the right care and support for the member and earn payment for the services they provide. Structured Family Caregiving helps members keep their dignity, self-respect, and privacy by offering high quality care at home instead of a care facility and supporting their independence. This service can provide options for members who are eligible for nursing facility level of care but can have their needs met at home.
Community Transitions	Community Transition Services (CTS) cover reasonable costs of setting up a home for members moving from an institution to their own home where they are in charge of their living expenses. Reasonable costs include expenses such as security deposits, essential home furnishings (e.g. a bed, eating utensils, housekeeping supplies), utility fees, and more.
Personal Emergency Response	Personal Emergency Response System (PERS) is an electronic device that helps members get 24/7 help in an emergency. The device is usually a portable help button but may also be a GPS or video monitoring device. It is programmed to call a response center when activated.
Integrated Health Care Coordination	Integrated Health Care Coordination improves members' health and quality of life by helping members along with their doctors manage chronic conditions using medical and social services. These services may include creating a healthcare support plan, providing skilled nursing services, medication management, transitional care between settings, advance care planning, and more.
Home Delivered Meals	Home Delivered Meals may include nutritionally balanced meals as well as personalized nutrition counseling and meal planning according to a member's needs.

Service	Service Definition
Home Modification Assessment	A home modification assessment check's a member's home to see what physical changes are needed to keep the member safely in their home.
Home Modification	Home modifications are physical changes that are needed to keep the member safely in their home. Home modifications may include but are not limited to: • Bathroom updates like installing a roll-in shower, grab bars, or accessible toilet. Adaptive switches and buttons to operate medical equipment • Home safety devices like door alarms or a handheld shower head • Ramp or stair lift
Home and Community Assistance	Home and Community Assistance services help with household tasks that members can't do themselves. Home and Community Assistance services may include but are not limited to: • Dusting and straightening furniture • Mopping and vacuuming floors and rugs • Cleaning the kitchen and bathroom • Laundry • Help with planning and preparing meals • And more.
Transportation	Services offered to help members in the waiver program get to waiver and other non-medical community services, activities, and resources. These are listed in the service plan. This service is offered in addition to medical transportation.
Nutritional Supplements	Nutritional supplements include liquid supplements, such as "Boost" or "Ensure" to support a member's health and ability to live in the community. Supplements must be ordered by your provider.
Pest Control	Pest Control services prevent pests like roaches, mosquitoes, fleas, bed bugs, mites, ticks, rats, or mice in the home.
Respite	Respite services are temporary or occasional services that are provided in the place of the usual caregiver. Respite can take place in home- and community-based settings.

Service	Service Definition
Specialized Medical Equipment and Supplies	Specialized Medical Equipment and Supplies are medically prescribed items that help members maintain their health and safety so they can be more independent at home. Specialized Medical Equipment and Supplies may include: • Lift chairs • Medication dispensers. • Slip resistant socks. • Voice active smart devices. • Interpreter service during service planning meetings
Vehicle Modification	Vehicle Modifications (VMOD) are changes to a vehicle to help members with safe transportation. Vehicle modifications may include: • Wheelchair lifts; • Wheelchair tie-downs (if not included with lift); • Wheelchair/scooter hoist; • Wheelchair/scooter carrier for roof or back of vehicle; • Raised roof and raised door openings; • Power transfer seat base.
Participant Directed Attendant Care Services	Participant Directed Attendant Care Services (PDACS) is when you choose to self-direct your attendant care services. This gives you more choice and control over who provides your personal care services and how your care is given. If you choose PDACS, you will have supports to help you manage some of the responsibilities, and you may appoint a representative to help you. Your service coordinator will provide you with educational materials about this option so you can make an informed decision about what is best for you.
Caregiver Coaching	The Caregiver Coach gives support, planning, and resources to the informal caregivers of Anthem members. The goal of this service is to reduce caregiver stress and burnout, improve caregiving skills and abilities, and help the Anthem member receiving care to be as healthy and independent as possible. The informal Caregiver Coach benefit is available to informal caregivers of Anthem members who need a nursing facility level of care. The informal Caregiver Coach benefit can be delivered virtually, by phone, by email, or through in-person visits. It is not available for those receiving Structured Family Care.

Caregiver Support

Anthem understands the important roles caregivers play in the health of our members. That's why we provide coaching and support for caregivers. We help caregivers support our members' needs. We also make sure caregivers have the tools and support they need to stay healthy. Whether a caregiver needs help trying to balance their job with family life and caregiving responsibilities, managing stress, maintaining a social life, or preventing burnout, Anthem can help. Call Member Services at **833-412-4405 (TTY 711)** Monday through Friday from 8 a.m. to 8 p.m. Eastern time to learn more.

Self-Direction
Self-Direction is a way of receiving attendant care that puts you in control. This service option allows you to hire the workers providing your care. Indiana PathWays for Aging allows you to select an agency to provide your attendant care, or you can choose to self-direct your attendant care services. This option is called Participant Directed Attendant Care Services (PDACS). This gives you more choice and control over who provides your personal care services and how your care is given. If you choose this option, you will have supports to help you manage some of the responsibilities, and you may appoint a representative to help you. Your service coordinator will provide you with educational materials about this option so you can make an informed decision about what is best for you.

Care and Disease Management Services

Anthem has two levels of care coordination services: Care Management and Complex Case Management. Both programs are described below.

Care Management
Healthcare can be overwhelming, so we're here to help you stay on top of it. Your care coordinator will help you:

- Create a care plan made specifically for your needs.
- Answer questions.
- Get you to the services you need.
- Coordinate with your doctors and support system.

If you have experienced a critical event or health issue that is complex, we'll help you learn more about your illness and develop a plan of care through our Complex Case Management program.

Complex Case Management
Complex Case Management services are available for adults with complex healthcare needs. Care coordinators meet with you to better understand your healthcare needs and use information about your medical history to find members who qualify for our Complex Case Management program. You can also be referred to Complex Case Management through:

- A medical management program referral.
- A discharge planner referral.
- A member or caregiver referral.

- A practitioner referral.
- 24/7 NurseLine.

Providers, nurses, social workers, and members or their representatives may refer you to complex case management in the following ways:

- Phone: **866-902-1690 (TTY 711)**
- Fax: **855-417-1289**
- Sydney Health mobile app: secure message center or live chat

A care coordinator will respond to a faxed request within three business days.

Complex Case Management is for members with:

- Three or more disease states which require the ongoing involvement of specialists to manage and deliver disease-appropriate care;
- Two or more "uncontrolled" disease states, which are defined as disease states requiring immediate attention, for which the member is not currently receiving disease-appropriate screening, follow-up appointments, care, therapy, and/or medication;
- Alzheimer's disease and related dementias (ADRD);
- An active cancer diagnosis, or the "uncontrolled/"uncompensated" disease states of heart failure, COPD, or diabetes with an A1c of greater than 9.0%;
- Palliative care service needs;
- Serious mental illness;
- Substance use disorder (SUD);
- Significant cognitive impairment;
- High dollar claims of over fifty thousand dollars (> $50,000) in six months;
- A nursing facility level of care (NFLOC) determination and who are receiving LTSS in a home- or community-based setting; or
- Housing stabilization needs.

Complex Case Management is also for members discharged from an inpatient psychiatric or substance use disorder hospitalization, for no fewer than 90 calendar days following the inpatient hospitalization. A care coordinator will be assigned to help you. The care coordinator will provide basic information about your condition, suggestions about questions to ask your doctor, and tips about how to stay healthy.

If you have one of these health issues or another complex or special health issue and want to learn more about complex case management, call **866-902-1690**.

Right Choices Program (RCP)

The Right Choices Program is for members who need help with using their health coverage appropriately. Its goal is to make sure your medical care is happening at the right time and place. If you're enrolled in this program, we'll send you a letter to let you know. Your team of experts will be made up of a PMP, a pharmacy, and a care coordinator. If you have questions about the Right Choices program, call Care

Management at **866-902-1690**.

State Ombudsman/Adult Protective Services (APS)
Anthem has a designated staff person, called a Member Advocate/Non-Discrimination Coordinator, who will help to work with you and any State Ombudsman or Adult Protective Services (APS) workers.

If you are living in a long-term care facility or other licensed assisted living facility, you will be provided with information on the State Long-Term Care (LTC) Ombudsman office. You can also reach out directly to the LTC Ombudsman at **800-622-4484** or **317-232-7134** or by email at **LongTermCareOmbudsman@ombudsman.IN.gov** with any concerns.

If you would like, the State Ombudsman and/or Adult Protective Services may participate as a member of your care team. You can discuss your wishes with your care or service coordinator or the Anthem Member Advocate.

Programs and Covered Services

From preventive care to vision and pharmacy services, we're here to help you get and stay healthy. Learn more about your PathWays benefits below.

Service[1]	Limitations/Coverage
Care Conferences	This is a time to meet with your care/service coordinators, your family or caregiver, and your care providers to discuss your healthcare needs. These conferences can happen in your home, telephonically, virtually, or at a location of your choosing.
Chiropractic Services*	Up to five visits per year and up to 50 therapeutic physical medicine treatments per year
Dental Care	Services include: • Two oral exams and one cleaning per year. • One set of bitewing X-rays and one complete set of X-rays every 3 years. • Medically necessary treatment. • Emergency treatment. • Comprehensive oral exam limited to one per lifetime, per member, per provider, with an annual limit of 2 per member. • Surgery for enlarged gums resulting from a drug side effect.
Diabetes Self-Management Training	Sixteen visits per member per year. More visits may be preapproved.
Pharmacy Services	Includes: • Prescription drugs • Over-the-counter (OTC) items approved by the Food and Drug Administration (FDA) and listed on the OTC medication list • Self-injectable drugs (includes insulin) • Needles, syringes, blood sugar monitors, test strips, lancets, and glucose urine testing strips • Drugs to help you quit smoking See the complete Preferred Drug List (PDL) at **anthem.com/inmedicaid** in the *Pharmacy Benefits* section.

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Service[1]	Limitations/Coverage
Legend Drugs	Medicaid covers legend drugs if the drug is: • Approved by the United States Food and Drug Administration • Not designated by CMS as less than effective or identical, related, or similar to a less than effective drug • Not specifically excluded from coverage by Indiana Medicaid The following drugs are not covered by PathWays and covered by Fee for Service: • Hepatitis C drugs • Hemophilia Agents • Spinal Muscular Atrophy Treatments • Muscular Dystrophy Treatments • CAR-T Therapies • Durable Genetic Therapy • Cystic Fibrosis Agents • Sickle Cell Agents
Non-legend Drugs	Medicaid covers non-legend (OTC — over-the-counter) drugs on its formulary. This is available via a link from the IHCP website at inm-providerportal.optum.com/providerportal/faces/PreLogin.jsp.
Emergency Services	Emergency services and all medically necessary services are covered.
Vision Services	Includes: • One exam every two years, unless more frequent care is medically necessary • One pair of glasses every five years • Contact lenses when medically necessary and not for cosmetic purposes
Food Supplements and Nutritional Supplements**	Coverage is available when no other means of nutrition is useful or reasonable. Routine or ordinary nutritional needs are not covered.
Hospital Services	Includes: • Emergency room • Inpatient services • Outpatient services and surgeries

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Service[1]	Limitations/Coverage
	• Lab tests and X-rays • Post-stabilization services • Ambulance transportation for emergencies
Home Health Services**	Coverage is available through home health agencies for: • Medically needed, skilled nursing services provided by a registered nurse or licensed practical nurse • Home health aide services • Physical, occupational, and respiratory therapy services • Speech pathology services • Renal dialysis for home-bound persons
Hospice Care**	Hospice is available under traditional Medicaid if end of life from illness is expected within six months. Care includes: • Two consecutive periods of 90 calendar days, followed by • An unlimited number of periods of 60 calendar days Members who need hospice services must disenroll from Anthem PathWays and enroll in traditional Medicaid.
Laboratory and Radiology Services	Services must be ordered by a physician or other practitioner who is approved to do so under state law.
Long Term Acute Care Hospitalization	Long term acute care services are covered. Prior approval is required.
Long-term services and supports (LTSS)	LTSS includes a wide range of services to help members live more independently. These services help with personal and healthcare needs and activities of daily living, such as • Eating • Bathing • Managing medication • Walking • Cooking • Transportation Care is provided in the home, in community-based settings, or in facilities, such as nursing homes.

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Service[1]	Limitations/Coverage
Medical supplies and equipment**	Medical supplies, equipment, and appliances suited for use in the home are covered when medically needed. Supplies may include prosthetic devices, implants, hearing aids, dentures, etc.
Mental health/Behavioral health services — Inpatient**	Inpatient mental health and behavioral health services are covered. Members that are admitted to a State psychiatric hospital must disenroll from PathWays.
Mental health/ Behavioral health services — Outpatient	Covered services include: • Partial hospitalization services • Intensive outpatient services • Individual, group, and family therapy • Mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as health service providers • Behavioral health services not provided by the above providers but including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers
Nonemergency transportation	Services include unlimited trips to: • Doctor visits and hospital discharges • Pharmacy and durable medical supply pick-ups • Medicaid renewal appointments
Nursing Facility Services (Long-term)**	Requires preadmission screening to decide level of care. Coverage includes: • Room and board • Nursing care • Medical and nonmedical supplies and equipment • Durable medical equipment • Medically needed and reasonable therapy services • Rides to vocational/habilitation service programs PathWays members who are living in a nursing facility for 30 days in a row or longer may be subject to patient liability. Patient liability is money you may need to contribute toward your monthly care. Patient liability will be determined by the state during initial enrollment and annual redetermination. The Office of Medicaid Policy &

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Service[1]	Limitations/Coverage
	Planning (OMPP) will be responsible for estate recovery activities, if applicable.
Nursing Facility Services (Short-term)	Services for members in a nursing facility setting on a short-term basis (i.e., for fewer than 30 calendar days).
Therapy services	Physical, speech, occupational, and respiratory therapies are covered. Services must be ordered by an M.D. or D.O. and provided by qualified therapist or assistant.
Organ Transplants	Coverage is according to current standards of medical care. Prior approval is required.
Orthodontics**	No orthodontic procedures are approved, except for cases of craniofacial deformity or cleft palate.
Out-of-state Medical Services**	Prior authorization is required, except for emergency services. Medicaid reimbursement is available for the following provided outside of Indiana: • Acute general hospital care • Physician services • Dental services • Pharmacy services • Transportation services • Therapy services • Podiatry services • Chiropractic services • Durable medical equipment and supplies • Hospice services, and • Diagnostic services
Provider Services*	Covered services include: • Reasonable services provided by an M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative, or palliative care, provided within the scope of practice. • PMPoffice visits. **Coverage Limits:** • PMP office visits: maximum of 30 per calendar year per member, per provider, without prior approval

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Service[1]	Limitations/Coverage
	• New patient office visits: one per member, per provider, within the last three years
Podiatry services	Up to six visits per year for foot care
Post-stabilization Services**	Covered services include care provided in the ER after your condition is stable or improved, but before you leave the ER. Prior approval is required.
Rehabilitative Unit Services — Inpatient**	Admission for inpatient services is based on the following criteria, showing the inability to function independently with proven impairment: • Cognitive function • Communication • Continence • Mobility • Pain management • Perceptual motor function • Self-care activities
Residential Substance Use Disorder (SUD) Services**	Prior approval is required for all residential SUD stays. Admission for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria: • ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services • ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services
Rural Health Clinics	Coverage is available for services provided by a: • Physician • Physician assistant • Nurse practitioner • Clinical psychologist or • Clinical social worker If you are homebound, services are offered only at clinics in areas where there is a shortage of home health agencies as determined by Medicaid.

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Service[1]	Limitations/Coverage
Smoking Cessation	Anthem can help you stop smoking. We cover one 12-week course of care per 12 months, which includes: • Prescription or over-the-counter products to help you stop smoking, such as nicotine patches or gum. • Counseling services. You can also receive help through Quit Now Indiana at **800-QUIT-NOW**. Go to **anthem.com/AnthemRewards** to find out how to earn money for quitting. To find more tools and resources, go to our *Health and Wellness* page at **anthem.com/inmedicaid**. Or call Member Services at **833-412-4405 (TTY 711)**.
Substance Use Disorder and Opioid Treatment Services*	Anthem covers recovery supports for substance use treatment, including: • Peer recovery services • Intensive outpatient • Partial hospitalization • Residential treatment • Medication assisted treatment Some services require prior approval. We also provide full coverage for Opioid Treatment Program (OTP) services, including: • All levels of care for methadone use • Medication assisted treatment • Associated counseling Prior approval <u>is not</u> required for OTP services. We contract with all Division of Mental Health and Addiction (DMHA) certified OTP providers across Indiana.

Self-Referral Services

PathWays includes some benefits and services that are available to members on a self-referral basis. These self-referral services do not require a referral from your PMP or approval. You can receive self-referral services from any Indiana Health Care Plan (IHCP) provider, even if they aren't contracted with Anthem, except for certain behavioral health services.

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

Self-referral services include:

- Routine dental services
- Chiropractic care
- Diabetes self-care training
- Emergency services
- Urgent care
- Eye and vision care (except surgical services)
- Family planning
- HIV/AIDS care management
- Podiatry services
- Immunizations
- Behavioral health/psychiatric services†

† Behavioral health providers who aren't psychiatrists must be contracted with Anthem.

The mental health and addiction providers to which a member may self-refer within the Anthem network are:

- Outpatient mental health clinics
- Community mental health centers (CMHCs)
- Psychologists
- Licensed psychologists
- Health services providers in psychology (HSPPs)
- Licensed social workers (LSWs)
- Licensed clinical social workers (LCSWs)
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses (APNs)
- Providers holding a master's degree in social work, marital and family therapy, or mental health counseling (under the Clinic Option)

Other Services

Indiana Health Coverage Programs (IHCP) covers some types of care for members. These types of services are called carve-outs. You may get these services from any IHCP-enrolled doctor. Carve-out services include:

- Medicaid Rehabilitation Option (MRO) — offers various mental health services to help members achieve their best health in daily life
- 1915(i) Waiver wrap-around services — includes services such as Behavioral and Primary Healthcare Coordination (BPHC) and Adult Mental Health and Habilitation (AMHH) services for members who may have special needs.

To find out more about these services, speak with your care coordinator, or call

Member Services at **833-412-4405 (TTY 711)**.

Excluded Services

The services below are excluded from coverage under the PathWays program, but available under Traditional Medicaid or other waiver programs.

Service	Description
Psychiatric Treatment in a State Hospital	PathWays members receiving psychiatric treatment in a state hospital will be disenrolled from PathWays so they can continue receiving treatment.
Intermediate Care Facilities for Individuals with Intellectual Disabilities	PathWays members who are admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will be disenrolled from PathWays and enrolled in Traditional Medicaid so they can continue receiving care.
Traumatic Brain Injury Waiver	PathWays members who become eligible for the Traumatic Brain Injury Waiver will be disenrolled from PathWays and enrolled in Traditional Medicaid so they can continue receiving these services.
Community Integration and Habilitation Waiver	PathWays members who become eligible for the Community Integration and Habilitation Waiver will be disenrolled from PathWays and enrolled in Traditional Medicaid so they can continue receiving these services.
Family Supports Waiver	PathWays members who become eligible for the Family Supports Waiver will be disenrolled from PathWays and enrolled in Traditional Medicaid so they can continue receiving these services.

Part 2 – Ways to Great Health

How to Choose your PMP

Now that you have selected Anthem, the next step is choosing a primary medical provider (PMP). Your PMP is the first person you call for all your healthcare needs. They will help you at any time, even after hours, and will respect your cultural and religious beliefs. Your PMP will take care of all your healthcare needs by coordinating:

- Checkups and vaccines.
- Requests to get an OK to give you services, if needed.
- Referrals to specialists.

- Referrals for tests and services.
- Admission to a hospital.

Your PMP can be a/an:

- Family physician or general practitioner (a doctor who treats people of all ages)
- Internist (a doctor who treats adults)
- Gynecologist (a doctor who deals with the female reproductive system)
- Clinic doctor (at a health department, health center, or rural health clinic)
- Advance practice provider, including a nurse practitioner or physician assistant
- An endocrinologist (if primarily engaged in internal medicine)
- Geriatrician (a doctor who treats older adults)

To select a doctor, or PMP, you can:

- Look inside Anthem's Provider Directory to find and choose a PMP.
- Go to **anthem.com/inmedicaid** and select *Find a Doctor*.
- Call Member Services at **833-412-4405 (TTY 711)**.

Provider Directory

Anthem provides members with an up-to-date Provider Directory to help you find a provider that is in the Anthem network. The directory can be found on **anthem.com/inmedicaid** and is ready for you to search based on your healthcare needs. Our Provider Directory tells you all about the doctors in your plan, including:

- Names, addresses, phone numbers, and office hours.
- Gender.
- Specialties.
- Languages they speak.
- Hospitals they work in.
- If they take new patients.
- Where they are located (using an online map).
- Medical school and residency completion.
- Professional achievements.
- Board certification status.

If you need a Provider Directory or help choosing a doctor who is right for you, visit **anthem.com/inmedicaid** or call Member Services at **833-412-4405 (TTY 711)**.

How to Change your PMP

It is best to keep the same PMP. They know your health needs. If you choose to see a doctor who is not your PMP and you did not get an OK from us first, you may have to pay for the services.

If you want to change your PMP, you can quickly do it online at **anthem.com/inmedicaid** or on the Sydney Health mobile app. Log in to access your secure account and change your PMP. If you don't have a secure account, you can create one at any time by selecting *Register now.* You'll need your member ID number located on your member ID card. We can also help you change your PMP over the phone by calling Member Services at **833-412-4405 (TTY 711)**.

American Indian/Alaska Native (AI/AN) Process to opt out of Managed Care
You have a choice to receive traditional Medicaid benefits instead of PathWays. You can call the Indiana PathWays for Aging Helpline at **87-PATHWAY-4** (**877-284-9294)** for questions about changing your health plan. It won't cost anything to change, and you may receive more benefits from traditional Medicaid than from PathWays.

AI/AN Anthem members can receive services from an Indian healthcare provider if eligible, including in- and out-of-state providers. Indian healthcare providers include providers operated by:

- Indian Health Service (IHS)
- Tribal Organization
- Urban Indian Organization
- An Indian Tribe

Also, if an Indian healthcare provider is in the Anthem plan, you can choose that provider as your PMP.

Program Helpline
Indiana PathWays for Aging — **87-PATHWAY-4 (877-284-9294)**

Changing your PMP
Member Services can assist you in finding your new PMP when:

- You have moved.
- Your doctor has moved, or no longer belongs to Anthem.
- You are not happy with the care you are receiving from your PMP.
- Someone in your PMP's office treated you rudely.
- Your doctor does not return your calls.
- You have trouble getting the care you want, or your PMP says you need.

Call Member Services at **833-412-4405 (TTY 711)** Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Health Plan Network Updates
Anthem will publish any updates to the provider network no less than 30 days prior to the effective date of the change. This means if there is a change that could impact your care, the health plan will provide the information to you within 30 business days.

How to access care
A PMP is a primary medical provider. Your PMP is your health partner. You will call them first when you need healthcare. They will work with you on all your healthcare needs. Your PMP will usually be able to help you with whatever you need. If your PMP is unable to treat your health issue, they will refer you to another place to get care.

Seeing a specialist
Your PMP may send you to a specialist for special care or treatment. They will help choose a specialist to give you the care you need. You may need permission from Anthem to see a specialist or receive certain care. Your PMP knows when to ask for permission.

Your PMP's office staff can help you get an appointment with a specialist. Make sure to tell your PMP and specialist as much about your health as you can. If your specialist or any other provider is not in the Anthem provider network, they must get permission from Anthem before they can give you care. You may also need a referral from your PMP.

If you have questions about care your doctor says you need, you may want a second opinion to make sure the treatment plan is right for you. To get a second opinion, talk to your PMP or call Member Services at **833-412-4405 (TTY 711)**.

How to make a doctor appointment
To make an appointment, call your PMP's office and request one. Make sure to have your member ID card in your hand when you call. Tell them you are an Indiana PathWays for Aging member and give them your member ID card information.

When you see your PMP, they will help you understand your medical needs. At your first appointment, your PMP will:

- Ask you questions about your current health and your medical history.
- Give you information on how to maintain your health.
- Schedule any tests and preventive care services you need.

Access to HCBS and LTSS
Anthem will provide information about the Indiana PathWays for Aging program to members upon enrollment and throughout the year. Outreach methods include:

- Face-to-face, field-based contact. This includes new member and health education workshops
- Phone calls
- Text messages
- Mobile app, member website, secure emails, live chat, blogs, and videos

- Newsletters, member handbook, and Quick Start Guides

More information can be found under the Care and Service Coordination section of the member handbook.

Out-of-Network Care
We contract with doctors to provide the care covered by your plan. Call your PMP or Member Services to find out if you need preapproval before seeing a doctor who isn't in your plan. You can also call us or visit our website to find a doctor in your plan. You may be able to see this out-of-plan doctor for a self-referral service. See *Self-Referral Services* section for more details. Anthem does not pay for costs from out-of-plan doctors in most cases. We can only give preapproval for those who are part of the Indiana Health Care Programs (IHCP), which means they're part of the state's plan.

There are a few other situations in addition to self-referral care where we will pay for out-of-plan services. These situations include:

- Services for which you had preapproval from your previous health insurer. We will honor those preapprovals (sometimes called authorizations) for at least 90 days after you join our plan.
- If your PMP leaves our plan, you may continue to see them while we work with you to find a new PMP within our plan.

In the unlikely event where we have not contracted with a provider who offers the services you need within 60 miles of your home, we will work with you to find a provider, even if that provider is out-of-plan.

If you get a service from a doctor who is not in our plan or the service is not approved, it will be considered an out-of-plan service. This doesn't apply to some self-referral services.

Special Benefit Provisions
As members of the Indiana PathWays for Aging program, you will not be charged copays for services or receive balance bills from providers for approved services, after all member liabilities are met.

Our goal is to make it easy for members to get the care they need. This includes out-of-network (OON) services if a network provider is not available. Anthem follows the state guidance to providing OON care with at least 30 calendar days advance notice. To receive payment from Anthem, an out-of-network provider must be IHCP certified. We will work to educate OON, network, and new providers on Anthem's billing and prior authorization policies and processes to simplify the process for members and providers.

Enhanced Benefits

On top of your regular PathWays benefits, PathWays members can receive extras just for being our member.

Person-centered support services	Details
Fresh Food Connect	Choice of home-delivered meals, farm fresh produce boxes, or a yearly membership for online grocery delivery.
Healthy Adults, Healthy Results	Online on-demand fitness and exercise videos, plus your choice of a home fitness kit to increase strength, flexibility, improve overall health, and help you stay in your home safely.
Personal Care Items	Up to $50 toward over-the-counter personal care essentials, including dental, nail, skin, and hair care products, laundry supplies, and germ prevention materials.
Memory Aids Kit	Memory care remembrance book, iron-on labels, decorative labels, markers, and an mp3 player with a music gift card to help improve symptoms of memory decline.
Companion Connect	Two smart speakers with video calling features — one for you and one for your loved one. Available to members in a nursing facility.
Healthy Lifestyle Aids	One healthy lifestyle aid per year, including items such as digital scales, lumbar pillows, and diabetic supplies.
Sensory Products	Up to $75 in coloring books, puzzles, games, arts and crafts, weighted blankets, and other sensory products to help improve memory and hand/eye coordination.
Help with smooth transitions	**Details**
Home essentials	Choice of a $50 thrift store card, a $50 discount store card, or up to $50 worth of basic household items, such as bedding, kitchen items, small appliances, and more.
Vision rehabilitation training	For members with visual impairments. Community- and home-based services to help you stay safely at home.
Post-discharge meals	Medically-tailored meals brought to your home after you return from an inpatient hospital or nursing home stay.
Home safety benefit	One home safety product per year to help prevent accidents and falls. Choose from items like carbon monoxide detectors, medication lock boxes, smoke alarms, night lights, and more.

Access to services	Details
Transportation essentials	Up to six round trips to the Social Security office, CHANGE/CAC Committee meetings, senior centers, group programs, renewal appointments, and health education classes. Choice of gas card or ride-share card up to $50 per year to help get you to other places you need to go.
Digital mental health toolkit	Manage stress, improve your mood, and get inspired with our online Emotional Well-being Resources and CommonGround Library.
COPD relief products	Select one COPD relief product, such as an inhaler vaporizer kit, travel nebulizer compressor system, hypoallergenic bedding, pillow and mattress cover, and HEPA air filters.
Smartphone Member Connect	Support and guidance in getting a smartphone and plan to stay in touch with family, friends, doctors, and social services.
Community Resource Link	Find help in your community with food, jobs, housing, and other things you may need. Visit **anthem.com/inmedicaid** to search for community resources near you.

Some benefits are limited to certain members only, and you may need to complete certain activities to be eligible. Enhanced benefits may change or end at any time. Go to **anthem.com/inmedicaid** to learn more.

Healthy Rewards for getting and staying healthy

At Anthem, we want you to be as healthy as you can be. Great health starts with preventive care. Preventive care may include any needed exams, screenings, or vaccinations. It's the care you get when you're not sick so your doctor can help you before you get sick. Your health is so important, we want to reward you for taking care of it.

There are many types of care you can get to earn incentives through our Healthy Rewards program. Talk with your doctor about preventive care that's right for you. We'll send you texts and emails to let you know which incentives apply to you. The first reward is for completing the Health Needs Screening (HNS) within 90 days of joining. You can complete the HNS with your care coordinator and earn your rewards. New Anthem members will receive more details about completing the HNS and other healthy activities. Go to **anthem.com/AnthemRewards** to find out what other rewards you may be able to earn.

Healthy Rewards program rules

- Medicaid must be your primary insurance.
- You must be an eligible Anthem member at the time the reward is used. If there is a lapse in your coverage after earning the reward, you will not be eligible to

use the reward.

- Your Healthy Rewards may only be used at participating retailers, like Amazon, DoorDash, Marshall's, and TJ Maxx in Indiana.
- The purchase of alcohol, tobacco, e-cigarettes, firearms, or prescription drugs is not allowed.
- You must have a valid email address.

How to start earning Healthy Rewards
Register by logging in to the Benefit Reward Hub to redeem your Healthy Rewards and view the rewards you are eligible for. You can also access your Healthy Rewards through the *My Health Dashboard* section of Sydney Health, our mobile app. Or call the Healthy Rewards customer service line at **888-990-8681 (TTY 711)**.

For more information about these programs, contact your care coordinator or call Member Services at **833-412-4405 (TTY 711)**.

Preventive Care

Seeing your doctor for preventive care is very important. Preventive care includes medical services you use to check your health to prevent and catch early symptoms of illness. It helps keep you healthy, especially as you get older.

Immunizations are shots that protect the body from disease and illness. Some immunizations require follow-up shots, or "boosters." These shots are given to you at certain times and are needed to prevent disease and help you maintain your health. If you're not sure if you have all your recommended shots, talk to your doctor right away.

All preventive care is paid for by Anthem. You are encouraged to use all preventive care services. See the chart below for preventive care services and immunizations for adult men and women.

Preventive care service	Women 50+	Men 50+
Annual physical exam*	X	X
Blood glucose testing*	X	X
Cholesterol testing*	X	X
Colorectal cancer screening	X	X
Pap smear*	X	
Screening mammogram*	X	
Dental exams*	X	X
Eye exams*	X	X
HIV and STD testing, treatment, and counseling	X	X
Screening for cancer and other related conditions	X	X

Immunizations		
Flu shot*	X	X
Pneumococcal vaccine*	X	X
Tetanus, diphtheria, pertussis booster	X	X
Shingles vaccine	X	X
Hepatitis B	X	X
COVID-19 vaccine*	X	X

* These services are usually provided annually, or as otherwise recommended by your doctor.

For more information about vaccines, visit **cdc.gov/vaccines**.

When and Where to Go for Care

It is important to know when and where to go for the medical care you need. Sometimes, it may seem difficult to decide where you should go when you or a family member doesn't feel well. Anthem has many options for care. The chart below shows some options for care and when they are the best option for you to use.

Primary medical provider (PMP)	Checkups and physicals, immunizations, minor aches and pains
Telehealth	For minor problems when you cannot see your PMP in-office. Telehealth is seeing your doctor remotely, usually by a video or audio call on your phone.
Convenience care clinic	For minor problems when your PMP is unavailable.
Urgent care	For problems that could become emergencies if left untreated for 24 hours. If you have an injury that could turn into an emergency if not treated within 24 hours, you need urgent care. Call your PMP or 24/7 NurseLine at **833-412-4405 (TTY 711)** if you have questions.
Emergency room (ER)	Life-threatening emergencies

Access to care

The chart below helps you understand when you can expect to get an appointment with your provider.

Provider type	Appointment category	Appointment standards
PMP	Routine	Within 30 calendar days
	Urgent	Within 24 hours

	Emergency	PMP emergency phone number is available 24 hours a day, 7 days a week
	Routine gynecological exam/New patient	Within 30 calendar days
	Annual physical exam	Within 90 calendar days
Specialist	Routine	Within 60 calendar days
	Urgent	Within 24 hours
	Emergency	24 hours a day, 7 days a week
Behavioral health	Non-life-threatening emergency	Within 6 hours
	Urgent	Within 24 hours
	Emergency	24 hours a day, 7 days a week
	Initial visit for routine care	Within 10 business days
	Follow-up routine care	Within 30 calendar days based on the condition
	Outpatient follow-up appointment	Within 7 days following discharge for the inpatient behavioral health hospitalization

24/7 NurseLine

24/7 NurseLine is a 24-hour, 7 days a week phone service staffed by specially trained registered nurses. Interpreter services are available 24 hours a day, 7 days a week for non-English speakers.

Access to 24/7 NurseLine allows members to access health services/education, optimize utilization, and refer to community-based health services. 24/7 NurseLine can also help members decide if an emergency room visit is needed.

24/7 NurseLine includes:

- Direct access to a registered nurse who can answer questions about your health concerns, medical conditions, prescription drugs, and local healthcare services.
- Notifications to let your providers know of a clinical contact with 24/7 NurseLine. 24/7 NurseLine contact reporting is available to Anthem for referral to care and service coordinators.

After-hours Care

Primary medical provider (PMP) after-hours coverage is available to you 24 hours a day, 7 days a week. Anthem maintains standards your PMP must follow. Your PMP or designated provider will answer your phone call after normal business hours in English and Spanish. After-hours coverage for your PMP may include an answering service or a shared-call service with other medical providers.

An urgent medical condition is not an emergency but needs medical care within 24 hours. It's not the same as a true emergency. Call your PMP if your condition is urgent, and you need medical help within 24 hours. If you cannot reach your PMP, call 24/7 NurseLine, even on holidays, at **833-412-4405 (TTY 711)**.

Urgent Care

If you have an injury that could turn into an emergency if not treated within 24 hours, you need urgent care. Call your PMP or 24/7 NurseLine at **833-412-4405 (TTY 711)** if you have questions. Urgent care symptoms include:

- Cold, flu, or sore throat
- Earache
- Vomiting or diarrhea
- Common sprain
- Minor broken bone
- Minor cuts
- Mild asthma/allergic reactions
- Rash without fever

Emergency Services

An emergency is a medical condition with severe symptoms that may be life threatening or cause serious damage to you. Examples of health problems needing emergency treatment include:

- Uncontrolled bleeding, major burns, seizures/convulsions
- Fainting, shortness of breath, severe chest pain, severe vomiting
- Cases of rape or molestation
- Poisoning
- A serious accident
- Broken bones

If you have an emergency, call 911 or go to the nearest ER. Do not call Anthem prior to calling **911**. You have the right to use any hospital or other setting for emergency care. Emergency room (ER) visits do not require prior approval for emergency services or post-stabilization care.

Make sure to call your PMP within 24 hours after you go to the ER or if you've checked into the hospital. Your PMP will set up a visit with you for follow-up care.

If you are experiencing a mental health crisis, call **988** for the National Suicide & Crisis Lifeline, or call **844-721-1304 (TTY 711)** for the Anthem Behavioral Health Crisis Hotline. Clinicians are available 24 hours a day, 7 days a week to talk with you.

Receiving emergency care outside our service area
If you need emergency care while you're traveling outside of our service area, follow these steps to help make sure you're covered:

- Call your PMP (or have the hospital call your PMP) if you need surgery, admission to the hospital, or any other services after you're stable
- Show your ID card to the hospital or doctor

If you are not sure if you are having an emergency, please call your PMP. If you cannot reach your PMP's office, you can call 24/7 NurseLine at **833-412-4405 (TTY 711)**.

The nurse can help you:

- Decide if you need to see your doctor
- Decide if you should go to the emergency room
- Answer general questions about your health

What is post-stabilization care?
This is the care you get in the ER or hospital after your condition is stable. Your doctor will examine you to make sure you're well enough to leave.

What if I receive a bill from my doctor?
In most cases, you should not get a bill from a provider. But you may have to pay charges if:

- You agreed in writing ahead of time to pay for care that is not offered by Anthem after you asked for an OK from us.
- You agreed ahead of time in writing to pay for care from a provider who does not work with us, and you did not get our OK ahead of time.

If you get a bill and you do not think you should have to pay for the charges, call Member Services at **833-412-4405 (TTY 711)**. Have the bill with you when you call and tell us:

- The date of service.
- The amount being charged.
- Why you're being billed.

Transportation

PathWays includes transportation (ride) benefits. Rides to the locations listed below are included in the PathWays plan through Anthem:

- Any doctor visit or healthcare appointment
- Your pharmacy
- Discharge from an inpatient hospital stay
- Urgent (upon approval) and recurring appointments
- Eligibility redetermination appointments with the State
- Senior centers, group programs, and health education classes

Please schedule a ride at least two business days before your appointment. Remember, if you have an emergency, please call **911** or go directly to the nearest emergency room. If you have questions, please call Member Services at **833-412-4405 (TTY 711)**. When you need a ride, follow these steps:

1. **Schedule your ride.** Call Anthem Transportation Services at **844-772-6632 (TTY 888-238-9816)** or book online at least two full business days in advance.
   - Calls for routine reservations are accepted Monday through Friday from 8 a.m. to 8 p.m. Eastern time.
   - Calls for urgent and same-day reservations are accepted 24/7.
   - Calls for cancellations, status updates, and hospital discharges are accepted 24/7.
2. **Set up your ride.** When you book, tell them your member ID number on your member ID card or date of birth, the date and time of your appointment, and if you need extra help, such as a wheelchair.
3. **Book your return trip.** When your appointment is over, call Anthem Transportation Services.

After you get care, ask the medical office to call the ride company for your return trip home. If you need to have a prescription filled at the office before leaving, work with your doctor to do so before calling your driver for the trip home. Your driver will need to be told about a stop at the pharmacy when scheduling the trip home.

When using ride services, please follow these rules:

- Wait for the driver at the curbside pick-up and drop-off site. The driver is only allowed to wait 15 minutes. If they wait too long, they will leave, and you will not be able to get a ride.
- If you must cancel your ride, you must call at least two hours before your set pick-up time.

If you are a member of an Anthem Dual Special Needs Plan (D-SNP), you have transportation benefits through both the Medicare part of your plan as well as Medicaid. Call PathWays Member Services at **833-412-4405 (TTY 711)** for help with your specific transportation needs and to ensure your ride is set up with the right transportation service provider.

Anthem Transportation Services can help you find out what transportation options are available in your area. Call Member Services at **833-412-4405 (TTY 711)** to find out about:

- Pick-up and drop-off services.
- Gas and mileage reimbursement.
- Bus tickets.
- Long distance trips.

Riders must follow state and local laws. This includes wearing seat belts and ensuring minor children are properly secured. Adults are responsible for providing the child's safety seat.

If your plans change, call Anthem Transportation Services as soon as possible, so the transportation provider can be informed. Rides are only provided to members who do not have other transportation. If you have reliable transportation, access to public transportation, or family and friends who can drive you, you must use these options first.

Transportation phone number: **844-772-6632 (TTY 888-238-9816)**

Behavioral Health and Substance Use Disorder

Behavioral health is about how you feel and act. It is also called mental health. Your mental health is very important. All PathWays members can receive mental health and substance use disorder services. You may see any in-network doctor without a referral for outpatient treatment. You may also see any IHCP-enrolled psychiatrist without a referral. If you are having thoughts about hurting yourself or someone else, call **988** immediately for help. If you have questions, please call Anthem's helpline below.

We cover care for mental health and substance use disorders for all PathWays members. You do not need a referral from your PMP to see someone for these services. Anthem Member Services can help you find a provider in your area. We cover:

- Inpatient services in a hospital
- Partial hospitalization
- Intensive outpatient program
- Individual, family, and group therapy
- Medication services
- Psychological testing
- Community-based services
- Substance Use Disorder (SUD) residential treatment
- Opioid Treatment Programs (OTPs)
- Applied Behavioral Analysis (ABA)
- Mobile crisis services

Your behavioral health provider or substance use treatment provider may ask you to sign a release of information to share information with your PMP. This will allow your providers to talk about your health conditions to ensure you receive the right care at the right time.

If you or someone you know needs support now, call or text **988** or start a chat at **988lifeline.org**. The 988 Suicide and Crisis Lifeline connects you with a trained crisis counselor who can help. If you have questions about behavioral health services, call Anthem at:

Behavioral Health Crisis Hotline: **844-721-1304 (TTY 711)**
Member Services: **833-412-4405 (TTY 711)**

Part 3 – Pharmacy Services

Pharmacy Information
Anthem covers medicines you need. You can go to any pharmacy that accepts your Anthem health plan. Prescription drugs, including injections and infusions, certain over-the-counter drugs, and pharmacy supplements, are benefits under the PathWays program.

Filling your prescriptions

- Your doctor will write you a prescription for medicine you may need.
- Your doctor will then contact your pharmacy, or you can go there with your prescription. Anthem works with CarelonRx to manage your pharmacy benefits.
- You must use a pharmacy that takes Anthem. This may include mail-order pharmacies. You can find Anthem pharmacies in our Provider Directory or by calling Member Services at **833-412-4405 (TTY 711)**.
- Your pharmacy benefits have a Preferred Drug List (PDL). The PDL has the medicines your plan pays for as long as you have a prescription. This includes over-the-counter (OTC) medicines. Find the complete PDL at **mss.anthem.com/in/insurance-plans/pharmacy-and-prescription-drugs.html**.

Pharmacy benefits for PathWays members include:

- Prescription drugs.
- Over-the-counter (OTC) items approved by the Food and Drug Administration (FDA) and listed on the OTC medication list.
- Self-injectable drugs (includes insulin).
- Needles, syringes, blood sugar monitors, test strips, lancets, and glucose urine testing strips.
- Drugs to help you quit smoking.

These prescription drugs are not offered:

- Over-the-counter (OTC) medicines (unless specified on formulary or PDL).
- Experimental or investigational drugs
- Drugs for cosmetic reasons
- Drugs for weight loss
- Drugs for hair growth
- Drugs to treat erectile dysfunction

Generic drugs
Generic drugs are as good as brand-name drugs. Your pharmacist will give you generic drugs when your doctor has approved them. Here are a few things you need to know:

- Generic drugs must be given when there is one available.
- Brand-name drugs may be given if there is not a generic drug for it.
- The PDL will tell you the exceptions to these rules.
- Generic and preferred drugs must be used for your condition, unless your doctor gives a medical reason to use a different drug.

Prior authorization
Some drugs need a prior authorization, or an OK, ahead of time. Your doctor must ask for an OK if:

- A drug is listed as nonpreferred on the PDL.
- Certain conditions need to be met before you get the drug.
- You're getting more of a drug than what is normally expected.
- There are other drugs that should be tried first.

If a prior authorization is needed, your doctor will need to give us details about your health. We will then decide whether Indiana Health Coverage Programs (IHCP) can pay for the drug. This is important because:

- You may need tests or help with a drug.
- You may be able to take a different drug.

Show your ID card to your provider. It has the phone number for preapproval requests. Anthem will decide within 24 hours after getting the request (not including Sundays or some holidays) if your drug request can be approved. Your doctor will be notified.

Medicare Part D
Medicare Part D drug benefit plans cover prescription drugs as approved by the Centers for Medicare & Medicaid Services (CMS). For full benefit, dual-eligible members, Indiana Medicaid covers medically necessary, federal and State reimbursable prescription drugs that are excluded from coverage by CMS under Medicare Part D benefit plans. Drugs eligible for coverage under Medicare Part D will not be covered under Medicaid, even if the member refuses Part D coverage.

Part 4 – Help with Special Services

Language Assistance

If English is not your main language, Anthem can provide you with an interpreter at no cost to you. To request assistance, please call Anthem Member Services.

If you are deaf or hard of hearing, Anthem can provide you with an American Sign Language Interpreter at no cost to you. To request assistance, please call Member Services at **833-412-4405 (TTY 711)**. You can get help in your language or sign language when you go to the doctor.

Anthem can give you reading materials in your language. If you need your member handbook and other health plan information in other ways, let us know. For example, if you need the information in another language, larger print, Braille, or in audio format, call Member Services at **833-412-4405 (TTY 711)**. Anthem will answer your questions in your language.

We offer services and programs that meet many language and cultural needs and help give you access to quality care. Our interpreter service works with more than 400 languages. We offer:

- 24-hour access to telephone interpreters.
- Member Services staff able to speak other languages.
- Sign language and face-to-face interpreters.
- Doctors who speak other languages.
- A Translator or oral interpreter (over the phone or face-to-face) when you are receiving healthcare services.
- Health education materials translated into different languages and other formats, such as Braille, large print, or audio CD.

We also help make sure oral interpretation services are available to members seeking healthcare-related and LTSS services in a provider's service office. This includes ensuring providers who have 24-hour access to healthcare-related services in their service locations or via phone (e.g., hospital emergency departments, PMPs) provide members with 24-hour oral interpreter services, either through interpreters or phone services. For example, we will ensure network providers offer TDD services for hearing impaired members, oral interpreters, and signers.

Tell your doctor if you need a sign language interpreter for your medical visits. **Call Member Services at least 72 hours in advance if you need an interpreter or translator at your PMP's office, other healthcare provider offices, or agencies supporting your healthcare needs.**

Language help
833-412-4405 (TTY 711)

Hearing and Speech Assistance

Call our toll-free Member Services line at **833-412-4405 (TTY 711)**, Monday through Friday from 8 a.m. to 8 p.m. Eastern time. If you need help between 8 p.m. and 8 a.m. or on weekends, call Relay Indiana at **800-743-3333 (TTY 711)**.

Americans with Disabilities Act

We meet the terms of the Americans with Disabilities Act (ADA) of 1990. This act protects you from discrimination by us because of a disability. If you believe you have been treated differently because of a disability, please call Member Services toll free at **833-412-4405 (TTY 711)**.

Redetermination

To continue receiving health coverage, you must renew your benefits. This is called a redetermination. Depending on your income at the end of each year of your coverage, you may have to show you are still eligible. Prior to your health coverage ending, a letter will be mailed to you from the Family and Social Services Administration (FSSA). The letter is called a "Notice of Renewal." Be sure to carefully read the directions that come with your renewal form. You may be required to sign the form and return it with some information. Contact the Division of Family Resources (DFR) at **800-403-0864** to ask questions. It can take about 45 days to complete your redetermination process. You will receive a notice from the DFR and Anthem to remind you about redetermination.

Anthem can assist you in the redetermination process. However, it is important to keep your address and phone number updated so you receive notices. If your phone number or address changes, contact the DFR online at **fssabenefits.in.gov**, or call **800-403-0864**.

Division of Family Resources (DFR) Toll-Free Line: 800-403-0864

Manage your benefits

Another option to report any changes is through the FSSA Benefits Portal. FSSA has developed an online tool that will allow you to manage your benefits, report changes, print proof of eligibility, and view your notices/correspondence. The Benefits Portal can be found at **fssabenefits.in.gov/bp/#**.

If you have other insurance

Call us at **833-412-4405 (TTY 711)** if you have other health benefits. This helps us work with your other insurance company to correctly pay claims. Also call us if you:

- Have a workers' compensation claim.
- Are waiting for a decision on a personal injury or medical malpractice lawsuit.
- Have a car accident.
- Become eligible for Medicare.

In some cases, Anthem may have the right to get back payments they made for you if another insurance company made payments for your healthcare. Let us know right

away if you were hurt in an accident or if another company made payments for your healthcare. You'll need to let us know information about what happened. **Call the Subrogation department at 866-891-7397 (TTY 711).**

Moving to Medicare

If you become eligible for a Medicare program, you must apply for Medicare. This includes if you are over 65 years old or have a disability. Medicare will help you apply as you get closer to your 65th birthday. If you become disabled, there is also Medicaid Disability. Your current health plan will help you apply for Medicaid Disability coverage.

When you move from your current health plan to a disability or Medicare program, your start date may be in the past. When your coverage changes, you may receive different benefits. Plan selection can be made on the Medicare application or by calling the enrollment broker within 60 days of coverage starting. If you do not select a plan, there will be an assignment process in place directed by the State. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered, such as the residential provider of the member (if applicable).

Open enrollment for Medicare is October 15–December 7 every year. During the open enrollment period, you can:

- Join, drop, or switch to another Medicare Advantage Plan (or add or drop drug coverage).
- Switch from Original Medicare to a Medicare Advantage Plan or from a Medicare Advantage Plan to Original Medicare.
- Join, drop, or switch to another Medicare drug plan if you're in Original Medicare.

Part 5 – Member Rights and Responsibilities

Member Rights

You and your provider can receive a copy of your Member Rights and Responsibilities by mail, fax, email, or on our website at **anthem.com/inmedicaid**. As a member of this health plan, you have the right to:

- Receive information about Anthem, the services we provide, Indiana PathWays for Aging managed care program, doctors and facilities in your plan, and your rights and responsibilities. You will also be notified by phone call or mail if benefits, services, or service delivery sites change or end. You can find information about Anthem on our website at **anthem.com/inmedicaid**. You can also call Member Services at **833-412-4405 (TTY 711)**.
- Use buildings and services that meet standards of the Americans with Disabilities Act (ADA). This means that people with disabilities or physical problems can get into medical buildings and use important services.
- Get information about Anthem's structure and operation.

- Be treated with respect and with due consideration for your dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a way that is right for your condition and that you can understand.
- Know that the date you joined Anthem is the date your benefits begin, and Anthem will not cover services you received before that date.
- Choose a primary medical provider (PMP) who is part of the network and change your PMP without cause or reason.
- Be free from any restrictions on freedom of choice among network providers.
- Know if your doctor takes part in a physician incentive plan through Anthem. Call us to learn more about this.
- Take part in all decisions about your healthcare. This includes the right to have and review a care plan and a service plan, and the right to refuse treatment.
- Get a second opinion from a different doctor.
- Receive covered services and medically necessary care in a timely and culturally competent manner.
- Have a care coordinator you can contact directly who will develop a care plan with you. Your care coordinator will work with you, your caregiver, your healthcare providers, and other service providers to assess your healthcare needs and ensure they are met.
- Have a service coordinator you can contact directly who will develop a service plan with you, if you are receiving home- and community-based services.
- Have the right to request a fair hearing if you are not given the choice of home- and community-based waiver services instead of institutional level of care, if you are denied the service(s) or the provider(s) of your choice, or if your services are denied, suspended, reduced, or terminated. The right to request a fair hearing includes providing a notice of action.
- Know which hospitals you should use and have access to them.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal laws on the use of restraints and seclusion.
- Request and receive a copy of your medical records. And you may request they be amended or corrected, as stated in state and federal healthcare privacy laws.
- Have honest talks with your doctors about the right treatment for your condition, in spite of the cost.
- Find out how Anthem decides if new technology or treatments should be part of a benefit.
- Have Anthem, your doctors, and all of your care providers keep your medical records and health insurance information private.
- Have your problems taken care of quickly. This includes things you think are wrong, as well as issues that have to do with your benefits, payment of services, or receiving an OK from us.
- Have access to medical advice from your doctor, either in person or by phone,

24 hours a day, seven days a week. This includes emergency or urgent care.

- Obtain interpreter services at no charge if you speak a language other than English, or if you have hearing, vision, or speech loss.
- Voice complaints or appeals about Anthem, the plan, or the care that we provide to you.
- Ask for information and other Anthem materials (letters, newsletters) in other formats. These include Braille, large-sized print, or audio CD, at no charge to you. Call Member Services at **833-412-4405 (TTY 711)**.
- Tell us what you would like to change about your Anthem health plan, including the member rights and responsibilities policy.
- Question a decision we make about the care you got from your doctor. You will not be treated differently if you file a complaint.
- Know that Anthem can make changes to your health plan benefits, as long as we tell you about them in writing before the changes take effect.
- Know that Anthem does not take the place of workers' compensation insurance.
- Ask about our quality program and tell us if you would like to see changes made.
- Ask us how we do utilization reviews and give us ideas on how to change them.
- Know you will not be held liable if Anthem becomes insolvent (bankrupt and cannot pay its bills).
- Make an advance directive.
- Know that Anthem, your doctors, or your other healthcare providers cannot treat you differently for these reasons:
    - Your age
    - Your sex or gender identity
    - Your sexual orientation
    - Your race
    - Your national origin
    - Your language needs
    - The degree of your illness, health condition, or disability

Member Responsibilities

As a member of this health plan, you have the responsibility to:

- Tell us, your doctor, and your other healthcare providers when you need help, how you prefer to be supported, and about your medical conditions to the best of your ability.
- Tell your doctor if you do not understand what they tell you about your condition, care, or what you need to do.
- Follow the rules of your doctor's office.
- Provide information to help us and your healthcare providers know how to support your healthcare needs.
- Take the lead in developing your treatment goals using support as needed.

- Follow through on your treatment plans (and instructions for care) you, your doctors, and your other healthcare providers agree to or let us know when the plan needs to be adjusted to help you to be successful with reaching your goals.
- Treat your doctor and other healthcare providers with respect.
- Make appointments with your doctor when needed or reach out to us for support as needed.
- Keep all scheduled appointments and be on time.
- Call your doctor if you cannot make it to your appointment.
- Always call your PMP first for all of your medical care (unless you have an emergency).
- Show your ID card each time you receive medical care.
- Use the emergency room only for true emergencies.
- Tell Anthem and the Division of Family Resources (**800-403-0864**) if:
    - You move.
    - You change your phone number.
    - You have any changes to your insurance.
    - Your income changes.
    - The number of people in your household changes.

Nondiscrimination

Anthem does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color, or national origin in providing aid, benefits, or services to beneficiaries. Anthem does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Anthem does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Anthem may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization, or person that discriminates on the basis of age. Anthem provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Anthem representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident, and is assisted in doing so if the member requests assistance. We document, track, and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of

Health and Human Services, Office for Civil Rights (OCR):

- Through the OCR complaint portal at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019 (TTY/TTD: 800-537-7697)**

Anthem provides free tools and services to people with disabilities to communicate effectively with us. Anthem also provides free language services to people whose primary language is not English.

If you believe that Anthem has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender, or gender identity, you can file a grievance.

Equal program access on the basis of gender
Anthem provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Anthem must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (such as race, color, national origin, gender, gender identity, age, or disability).

Anthem may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Advance directives

Advance directives are instructions you give about your future medical care, in case there is a time you can't speak or make decisions for yourself. By having an advance directive in place, this will not take away your right to decide your current healthcare choices. The advance directive also allows you to name a person to make decisions on your healthcare. They help your family and physician understand your wishes. With advance directives, you can:

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

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

- Talking to your doctor and family
- Choosing someone to speak or decide for you, known as a healthcare

representative
- Creating a Power of Attorney

Types of advance directives recognized in Indiana
- Organ and tissue donation
- Health Care Representative
- Psychiatric advance directives
- Out of Hospital Do Not Resuscitate Declaration and Order and Physician Orders for Scope of Treatment (POST)
- Power of Attorney

For more information on advance directives and to find forms available to you, please visit the Indiana Health Care Quality Resource Center at **in.gov/isdh/25880.htm**.

Outreach and Education Regarding Critical Incidents

A critical incident is an event that impacts your health, safety, and welfare. Critical incidents may involve suspected abuse, neglect, and/or exploitation. You have a right to:
- Report critical incidents that affect your health and safety.
- Be free from any retaliation for reporting a critical incident.
- A process that will ensure your immediate safety.
- Understand the steps in an investigation, including timelines.
- A follow-up from the appropriate entity conducting the investigation.
- Participate in discussions about your care and how to prevent future risks.

Providers, care coordinators, service coordinators, and other Anthem staff are provided training on how to recognize and report critical incidents.

The information below provides a description of the three types of critical incident categories, how you can make a report, and outlines the next steps in the process after a report is made.

Critical incident categories and reporting

There are three types of critical incident categories:
- Abuse, neglect, and exploitation (ANE)
- Home- and community-based services (HCBS) critical incidents
- All other critical incidents

Abuse, neglect, and exploitation (ANE)

You have the right to be free from abuse, neglect, and exploitation. It's important you know how to identify abuse, neglect, and exploitation and how to report it.

Abuse is when a person knowingly or intentionally:
- Touches another person in a rude, disrespectful, or angry manner; or
- Places any bodily fluid or waste on another person.

Neglect can happen when:

- An adult can't care for themselves or get needed care, placing their health or life at risk — this is "self-neglect."
- A dependent adult's basic needs aren't provided by a caregiver, causing harm or risk of harm to their health or safety. The neglect may be accidental due to the caregiver not providing or setting up the care or services the person needs. Neglect can also happen when the caregiver doesn't meet the member's needs on purpose.

Exploitation of an individual's personal services or property can happen when:

- Another person recklessly, knowingly, or intentionally uses the services or property without permission.
- Another person takes advantage of an individual's work or labor without pay, or has control over an individual's finances or property without permission.
- Another person sexually exploits an individual.

The state of Indiana is a mandatory reporting state. This means everyone is required by law to report cases of suspected neglect, abuse, exploitation, or unexpected death of an endangered adult to Adult Protective Services (APS) or law enforcement within 24 hours of the occurrence or knowledge of the occurrence. If you think you are a victim of abuse, neglect, or exploitation, you may call **211** to make a report, call the APS hotline at **800-992-6978**, or file a report online here: **aps-govcloud.my.site.com/APSOnlineReport/s**. All reports are secured and kept confidential. If you believe someone is in immediate danger, call **911** immediately.

Home- and community-based services (HCBS) critical incidents

Providers of home- and community-based services have a responsibility to ensure the health, safety, and welfare of the individuals they serve. Anyone with direct monitoring responsibilities of individuals, including HCBS providers, care coordinators, service coordinators, and other PathWays staff members, has a responsibility to report critical incidents, known as unusual occurrences. A comprehensive list of critical incidents identified as unusual occurrences can be found on the Anthem member website.

When an HCBS critical incident occurs, a report must be made within 48 hours of the time of the incident or becoming aware of the incident. HCBS providers are required to notify the member's care/service coordinator about a critical incident. If you are concerned about a critical incident and/or reporting, contact your care/service coordinator. Critical incident reports are submitted through the Division of Aging Reportable Incident website at **in.gov/fssa/da/provider-resources/provider-information/incident-reporting**. Members and caregivers may also report critical incidents at this website.

Anthem tracks incidents and reviews and analyzes this information to identify patterns, trends, indicators of quality of care, and/or health and safety concerns.

Anthem reviews this information during quality improvement committee meetings. This information is also provided to the Family and Social Services Administration (FSSA), along with proposed strategies to address critical incidents. FSSA provides an analysis of statewide critical incident patterns and trends so that further actions for improvement can be identified.

All other critical incidents
Critical incidents may occur in locations other than home- and community-based settings. Providers, care coordinators, service coordinators, and other PathWays staff members report critical incidents to the appropriate entity.

When a care/service coordinator or other Anthem staff becomes aware of an incident that falls into the category of "all other critical incidents," the care/service coordinator or staff reports the incident to the appropriate entity and takes immediate action to protect your health, safety, and welfare. Anthem will cooperate with the state entity investigating the incident. If a state entity notifies Anthem of an incident, your care/service coordinator will take immediate action to protect your health, safety, and welfare. As findings are shared with your care/service coordinator, action will be taken as necessary to further protect your health, safety, and welfare, as well as any other members who may be potentially at risk.

Finding support and help
If you or someone you know feels they are at risk for experiencing a critical incident, reach out to someone you trust to share your concerns. Asking for help can be hard, but connecting with others you trust is the first step in ensuring you have the support and help you need to live a quality life. Connecting or reconnecting with family or friends is only one way to find support and help. Additional ways to stay connected and promote mental and physical well-being may include adopting a pet or finding a faith-based organization or community center.

There are several factors that may increase or decrease the risk of experiencing a critical incident. A caregiver under stress or feeling isolated may increase this risk. Caregiving can be a highly stressful activity that can cause someone to feel isolated, ambivalent, irritable, worried, depressed, sad, or overwhelmed. Having resources and services such as respite, building a larger support system, and participating in support groups can help to alleviate caregiver stress. Your care/service coordinator can provide additional local referrals and resources. Caregiving articles and resources are also available at the National Institute on Aging website, **nia.nih.gov**.

Part 6 – How to Resolve a Problem with Anthem

How to get help

It is important that you are receiving the best care from Anthem and your providers. If you have a concern or question, you can call Member Services at **833-412-4405 (TTY 711)**. Member Services can help you with things like:

- Finding a doctor
- Finding care and treatment
- Understanding how your Anthem health plan works
- Answering questions about any part of your healthcare

You will not be treated any differently if you call with a complaint or grievance.

Grievances and Appeals

Grievances

If you have a complaint or problem with the care you are getting, you can file a grievance with Anthem. A grievance can be a written letter or a phone call. A grievance can be filed at any time after a problem happens.

You can first talk to your doctor or provider if you have any questions or concerns about your care. They can work with you on fixing the problem. If the problem isn't fixed, you can call Anthem.

If you have questions or concerns about not getting the care you need, you will file an appeal with Anthem. You can file an appeal in writing or by calling Member Services at **833-412-4405 (TTY 711)**.

Grievance process

- Anthem will send an acknowledgment letter within three business days after reporting a grievance.
- The grievance will be reviewed quickly, no later than within 30 days following receipt of the grievance.
- If your grievance is a result of a health crisis, please request an expedited (faster) review within 48 hours.
- Once a decision has been made, Anthem will mail you a letter in your primary language.

You have four ways to file a grievance with us:

1. Call Member Services at **833-412-4405 (TTY 711)**.
2. Complete a grievance form found on **anthem.com/inmedicaid**.
3. Write us a letter to tell us about the problem. These are the things you need to tell us as clearly as you can: who is involved in the grievance, what happened, when did it happen, where did it happen, and why you're not happy. Mail your

completed form or letter, along with any documents, to:

Grievance Coordinator
Anthem Blue Cross and Blue Shield
P.O. Box 62429
Virginia Beach, VA 23466

4. Or fax your completed form or letter, along with any documents to: **855-516-1083**.

Just cause grievances

There might be a time when you want to change your Anthem health plan, but are not in your plan selection time. You may be able to due to certain reasons called "just cause." If you have one of these reasons, you need to file a just cause grievance with Anthem to see if you can change plans. The following are the "just cause" reasons for switching health plans during the year for the PathWays program:

- Receiving poor quality of care
- The plan does not, because of moral or religious objections, cover the needed services
- Failure of the health plan to provide covered services
- Failure of the health plan to comply with established standards of medical care administration
- Significant language or cultural barriers
- Corrective action levied against the health plan from FSSA
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence
- A determination that another MCE's formulary is more consistent with a new member's existing healthcare needs
- The member's primary healthcare provider disenrolls from the member's current MCE and re-enrolls with another PathWays MCE; or
- Other circumstances determined by the FSSA or its designee to constitute poor quality of healthcare coverage.

If you have a "just cause" grievance, call Anthem at **833-412-4405 (TTY 711)**. We will review your request and answer your questions.

Call **87-PATHWAY-4 (877-284-9294)** if you want help filing a grievance or changing your Anthem health plan.

Appeals

If you disagree with any action that denies or delays your care, you can file an appeal. An appeal is asking for a review because you do not agree with a decision the State, or Anthem has made. You have the right to file an appeal if you disagree with the decision. You do not have to pay to file an appeal. You can also appeal if Medicaid or Anthem stops providing or paying for all or part of a healthcare service, supply, or

prescription drug you think you still need.

- If you are on Medicaid and want to appeal a decision made about your healthcare, you can appeal in writing or over the phone to Anthem.
- If you are in the PathWays program, you should contact Anthem and work through their appeal process. You have 60 calendar days from the date of the problem to appeal.
- If you file an appeal, you will continue to get any services you were already getting, as long as you file the appeal quickly. You must file an appeal within 60 calendar days from the date of the *Notice of Adverse Benefit Determination* letter. If the appeal is not decided in your favor, you may have to pay for the services you received during the appeal process.

You have three ways to file an appeal with us:

1. Call Member Services at **833-412-4405 (TTY 711)**
2. Fax your appeal to: **855-516-1083**
3. Send your appeal to:
   Grievance Coordinator
   Anthem Blue Cross and Blue Shield
   P.O. Box 62429
   Virginia Beach, VA 23466

State Fair Hearing

Once a decision is made on your appeal, a *Notice of Appeal Resolution* letter will be sent to you. This letter will tell you the reason for the decision. If you feel the decision is not correct, you may request a State Fair Hearing. You can write a letter telling the State why you think a decision is wrong. Please make sure to also include your name and other important information, like the dates of the decision, which is on the letter.

You have three ways to file an appeal with FSSA:

1. Fax your appeal to: **317-232-4412**
2. Email your appeal to **fssa.appeals@oalp.in.gov**
3. Mail your appeal to:
   Family and Social Services Administration
   Office of Administrative Law Proceedings-FSSA Hearings
   402 W. Washington St., Room E034
   Indianapolis, IN 46204

Appeals regarding eligibility decisions can be sent to the local Division of Family Resources (DFR) office. To find a DFR office near you, go to **in.gov/fssa/dfr/2999.htm**.

If you file an appeal, you must do it within 120 calendar days after your problem happened or is set to happen. If your appeal is about a service you are still using, like in-home healthcare, you will get at least 10 days' notice before your service is stopped.

At your appeal hearing, you can speak for yourself or have help, or representation, from legal counsel, a friend, relative, or someone you trust to speak on your part. You will be shown your entire medical case file. You will be shown all materials used by FSSA, your county office, or the provider or health plan that relates to your appeal and used to make the original decision.

External Review by Independent Review Organization

If you do not agree with the appeal decision, you may also request an External Review by an Independent Review Organization (IRO). You or your authorized representative must request the IRO review in writing within 120 calendar days of receiving your appeal decision letter. The IRO will be conducted at no cost to you. The IRO will decide within 15 business days. The decision by the IRO is binding, meaning Anthem must obey their decision. To request the External Review by Independent Review Organization, reach out to Anthem Member Services.

Information to include when requesting an External Review:

- Name
- Member ID number
- Phone number where you can be reached
- Reason for your appeal
- Any information you feel is important to your appeal request (Examples include documents, medical records, or provider letters.)

Choosing a New Health Plan

You can change to a different health plan for any reason during the first 90 days of membership. You can also change your Anthem health plan:

- Any time your Medicare and Medicaid plans are not the same.
- Once per calendar year for any reason at any time.
- Using the just cause process.
- During the health plan selection period (mid-October to mid-December).
- If you are an American Indian/Alaska Native (AI/AN) choosing to not use managed care and change to State fee-for-service benefits.

You can change health plans for “just cause” at any time if:

- You have exhausted Anthem’s internal grievance process due to receiving poor quality of care, or if there are other instances that are determined to be poor quality of care.
- We can’t provide covered services.
- We fail to comply with certain medical standards and practices.
- There is a lack of access to providers experienced in dealing with your healthcare needs.
- There are language or cultural barriers.
- You have limited access to primary care clinics or other health services near you.

- Another managed care entity (MCE) has a list of drugs that's better for your healthcare needs.
- You don't have access to medically necessary services offered by Anthem.
- A service is not covered by us for moral or religious reasons.
- You need a group of related services at the same time and not all related services are available in our health plan, and your provider says getting the services separately will be a risk to you.
- Your primary medical provider (PMP) leaves Anthem and is enrolled with another MCE.
- Corrective action levied against the Contractor by the office.
- Other circumstances determined by the Office of Medicaid Policy and Planning (OMPP) or its designee to constitute poor quality of healthcare benefits.

How to change health plans

At certain times each year, you can choose to change your Anthem health plan. You can stay with your current health plan, or you can switch to a different one. You can only switch health plans during your plan selection time period, or for just cause. Right Choices Program members are not eligible to change plans.

PathWays members have plan selection for the first 90 days they are eligible for coverage. Look out for a notice for your PathWays plan selection time.

If you have a question about changing your Anthem health plan or want to get the MCE change form to file a written change request, call the Indiana PathWays for Aging Helpline at **87-PATHWAY-4 (877-284-9294)**.

Fraud, Waste, and Abuse

Fraud, waste, and abuse means breaking the rules for a personal gain. Fraud can be committed by providers, pharmacies, or members. Examples of provider fraud, waste, and abuse include doctors or other healthcare providers who:

- Prescribe medicine, equipment, or services that are not medically necessary
- Don't provide patients with medically necessary services due to lower reimbursement rates
- Bill for tests or services that were not provided
- Use wrong medical coding on purpose to get more money
- Schedule more frequent return visits than are medically necessary
- Bill for more expensive services than provided
- Prevent members from getting covered services, resulting in underutilization of services

Examples of pharmacy fraud, waste, and abuse include:

- Not dispensing drugs as written
- Submitting claims for a more expensive brand-name drug that costs more, but giving a generic drug that costs less
- Dispensing less than the prescribed quantity, and not letting the member know how to get the rest of the drug

Examples of member fraud, waste, and abuse include:

- Inappropriately using services, such as selling prescribed narcotics or trying to get controlled substances from more than one provider or pharmacy
- Changing or forging prescriptions
- Using medications that you do not need
- Sharing your ID card with another person
- Not disclosing that you have other health insurance coverage
- Getting unnecessary equipment and supplies
- Receiving services or medicines under another person's ID (identity theft)
- Giving wrong symptoms and other information to providers to get treatment, drugs, etc.
- Visiting the ER repeatedly for problems that are not emergencies

Medicaid members who are proven to have abused or misused their covered benefits may:

- Be required to pay back any money we paid for services which were determined to be a misuse of benefits
- Be prosecuted for a crime and go to jail
- Lose their Medicaid benefits

Reporting fraud, waste, or abuse

If you think your doctor, pharmacy, or a member is committing fraud, waste, or abuse, you must tell Anthem. You can call Anthem's fraud reporting line, send an email, or fill out and mail a form. You do not have to tell them your name if you call or write. If you do not give your personal information, Anthem will not be able to call for other information. Do not send any sensitive personal information through email. Your report will be kept confidential to the extent permitted by law.

Fraud reporting lines

Call toll-free **800-403-0864**, Monday through Friday, 8 a.m. to 4:30 p.m. Select **option 5**. When prompted, enter your ZIP code.

Fax: **317-234-2244**
Email: **ReportFraud@fssa.IN.gov**

Fraud Reporting mailing address:
FSSA Compliance Division, Room E-414
402 W. Washington St.
Indianapolis, IN 46204

Index

Words and acronyms used in this manual

Advance directive	A written explanation of a person's wishes about medical treatments. This makes sure wishes are done if a person cannot tell a provider.
Annual physical	Visits to a primary medical provider (PMP) each year to check your health.This is often referred to as a wellness visit, preventive health exam, or checkup.
Appeal	A written or verbal request for a decision to be reversed.
Benefit	Healthcare service coverage that a Medicaid member receives for the treatment of illness, injury, or other conditions allowed by the State.
Care management	Program for members with special health conditions that help members manage their conditions by routine contact and help from their health plan.
Care coordinator	A care coordinator is a person who may contact you to create a personalized care plan based on your preferences and needs. They can also help answer questions about your healthcare and help you with your providers.
Copayment	A form of cost sharing. Copayments, or "copays," refer to a specific dollar amount that an individual will pay for a particular service, regardless of the price charged for the service. The payment may be collected at the time of service or billed later.
Covered service	Mandatory medical services required by CMS and optional medical services approved by the State that are paid for by Medicaid. Examples of covered services are prescription drug coverage and physician office visits.
Division of Family Resources (DFR)	A division of the Family and Social Services Administration. The State agency that offers help with job training, public assistance, supplemental nutrition assistance, and other services.
Eligible member	Person certified by the State as eligible for medical assistance.
Explanation of Benefits (EOB)	An explanation of services rendered by your provider and any payments made toward those expenses.

Family and Social Services Administration (FSSA)	An umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.
Grievance	A complaint about the health plan or providers.
Health Needs Screening (HNS)	A questionnaire members must complete so their health plan is aware of any healthcare conditions. This allows the health plan to match the members with the right programs and services.
Home- and community-based services (HCBS)	Home- and community-based services (HCBS) are services for eligible individuals who choose to remain in their home as an alternative to residing in a long-term care institution, such as a nursing facility. These services assist a person to be as independent as possible and live in the least restrictive environment possible while maintaining safety in the community. Not all PathWays members are eligible for HCBS. They are only available for individuals who have a nursing facility level of care (NFLOC) determination.
Indiana Health Coverage Programs (IHCP)	The name used to describe all of Indiana's public health assistance programs, such as Medicaid, PathWays, and CHIP.
In network	When a doctor, hospital, or other provider accepts your health insurance plan, that means they are in network. We also call them participating providers.
Managed Care Entity (MCE)	Organizations or health plans that oversee the overall care of a patient so as to ensure cost-efficient, quality healthcare to its members.
Medicaid identification number	The unique number assigned to a member who is eligible for Medicaid services. This number can be found on the front of your member ID card.
Medically necessary	Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.
Non-participating provider	A licensed healthcare professional who has not signed a contract to give services. This could be a doctor, hospital, or other provider.
Primary medical provider (PMP)	A physician or advanced practice nurse, the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary medical provider.

Prior authorization (PA)	An authorization required for the delivery of certain services. The Medical Services Contractor and State medical consultants review PAs for medical necessity, reasonableness, and other criteria. The PA must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances.
Service coordinator	A service coordinator is a person who will work with you to create a personalized Service Plan to help coordinate your home- and community-based services (HCBS). The Service Plan will help develop a plan of care of services and supports that best meet your needs and goals.
Service plan	A service plan is a support plan, developed by a service coordinator, for assisting you in gaining access to long-term care services, as well as medical, social, housing, educational, and other supports. Not everyone in PathWays will need a service plan.

Notice of Privacy Practices

This notice describes how health information about you may be legally used and shared. If your information is used, Anthem must follow the State and federal rules. You have the right to know what was shared.

Rights

You have rights as an Indiana PathWays for Aging member. Anthem must follow rules about your rights. Your rights include the ability to:

- Get a copy of your health and claims records
- Ask to fix your health and claims records if you think they are wrong or not complete
- Ask for private communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Give Anthem consent to speak to someone on your behalf
- Have information needed to make informed decisions
- Request a new care or service coordinator
- Select your providers
- Be in charge of your healthcare decisions
- File a complaint if you feel your rights are violated
    - You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:
        - Sending a letter to 200 Independence Ave. SW, Washington, D.C. 20201.
        - Calling **877-696-6775**.
        - Visiting their website at **https://www.hhs.gov/hipaa/filing-a-complaint/index.html**.

Choices

You can choose what information we share and with whom we share it. You may have to give written permission to share.

If you can't choose, such as while being unconscious, Anthem may share information if they believe it to be in your best interest. We can help you to identify someone you trust to make decisions on your behalf if you are not able to do so.

Anthem may not be able to share your information with people unless you give written consent. These may be people like a family member or close friend who pays for your care.

Uses

Anthem uses your information for different things. They use it to help get you better

care, to do research, and to follow the law.

Responsibilities
Your information is protected in many ways. This includes your information that is written, spoken, or available online. Anthem is trained on how to protect your information. Very few people can access your information. Anthem is required by law to keep the privacy and security of your health information. If a breach occurs, Anthem will let you know quickly.

Anthem must follow the duties and privacy practices described in this notice. They must give you a copy of it. Anthem will not use or share your information other than as listed here, unless you tell them they can in writing.

You may change your mind at any time. Let Anthem know in writing if you change your mind.

Do you need help with your healthcare, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.

Spanish

¿Necesita ayuda con su cuidado médico, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos gratuitamente al 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.

Arabic

هل تحتاج لمساعدة فيما يتعلق برعايتك الصحية أو تحتاج للحديث معنا أو قراءة ما نرسله لك؟ نوفّر المواد الإرشادية بلغات وصيغ أخرى، دون أي تكلفة عليك. اتصل بنا على الرقم المجاني 866-408-6131 (Hoosier Healthwise؛ Healthy Indiana Plan)؛ 844-284-1797 (Hoosier Care Connect)؛ 833-412-4405 (Indiana PathWays for Aging)؛ TTY 711.

Burmese

သင့်ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် ပတ်သက်၍ဖြစ်စေ၊ ကျွန်ုပ်တို့နှင့် ဆွေးနွေးရာတွင်ဖြစ်စေ၊ ကျွန်ုပ်တို့ပို့လိုက်သည့်စာကို ဖတ်ရှုရာတွင်ဖြစ်စေ အကူအညီလိုအပ်ပါသလား။ ကျွန်ုပ်တို့၏အချက်အလက်စာရွက်စာတမ်းများကို အခြားဘာသာစကားများ၊ ပုံစံများဖြင့် သင့်အတွက် အခမဲ့ ပံ့ပိုးပေးပါသည်။ 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711 တွင် ကျွန်ုပ်တို့ထံ အခမဲ့ ဖုန်းခေါ်ဆိုပါ။

Chinese

您在健康護理方面、與我們交流或閱讀我們寄送的材料時是否需要幫助？我們以其他語言和格式提供我們的資料，您無需支付任何費用。請撥打免費電話聯絡我們：866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan)；844-284-1797 (Hoosier Care Connect)；833-412-4405 (Indiana PathWays for Aging)；TTY 711。

Dutch

Hebt u hulp nodig bij uw gezondheidszorg, om met ons te praten of bij het leesmateriaal dat we u sturen? We verstrekken onze materialen in andere talen en indelingen zonder extra kosten voor u. Bel ons gratis op 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.

Avez-vous besoin d'aide pour vos soins de santé, pour communiquer avec nous ou pour lire les documents que nous vous envoyons ? Nous mettons gratuitement à votre disposition nos documents dans d'autres langues et formats. Appelez-nous gratuitement au 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan) ; 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging) ; TTY 711.	*French*
Benötigen Sie Hilfe bezüglich Ihrer Gesundheitsversorgung, möchten Sie mit uns sprechen oder haben Sie Probleme, die von uns zugesandten Materialien zu lesen oder zu verstehen? Wir stellen unsere Materialien kostenfrei in anderen Sprachen und Formaten bereit. Rufen Sie uns gebührenfrei an unter 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan), 844-284-1797 (Hoosier Care Connect), 833-412-4405 (Indiana PathWays for Aging), TTY 711.	*German*
क्या आपको अपनी स्वास्थ्य देखभाल, हमसे बातचीत करने या हमारी ओर से भेजी गई चीज़ों को पढ़ने में मदद चाहिए? हम अपनी सामग्री आपको दूसरी भाषाओं और फ़ॉर्मेट में मुफ़्त उपलब्ध कराते हैं। हमें टोल फ़्री नंबर 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711 **पर फ़ोन करें।**	*Hindi*
ヘルスケアの受診、ご相談時の会話、配布物の読解にお困りではありませんか？当院では無料の翻訳版資料をご用意しております。フリーダイヤルへお電話ください：866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.	*Japanese*
의료 서비스, 당사와의 소통 또는 당사에서 보내는 자료 읽기와 관련해 도움이 필요하십니까? 자료를 다른 언어및 형식으로 무료로 제공해드립니다. 수신자 부담 전화866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan), 844-284-1797 (Hoosier Care Connect), 833-412-4405 (Indiana PathWays for Aging), TTY 711으로 연락하십시오.	*Korean*
Brauchscht du Hilf fer Care griege, fer schwetze mit uns, odder fer Schtofft lese as mer dich schicke? Mir gewwe dich uffgschriwwener Schtofft in differnti Schprooche un Formats unni as es dich ennich eppes koschte zellt. Ruf uns uff fer nix an die 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.	*Pennsylvania Dutch*

ਕੀ ਤੁਹਾਨੂੰ ਆਪਣੀ ਹੈਲਥ ਕੇਅਰ, ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ, ਜਾਂ ਅਸੀਂ ਤੁਹਾਨੂੰ ਜੋ ਸਮੱਗਰੀ ਭੇਜਦੇ ਹਾਂ ਉਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਮਦਦ ਚਾਹੀਦੀ ਹੈ? ਅਸੀਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਸਮੱਗਰੀ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਅਤੇ ਫ਼ਾਰਮੈਟਾਂ ਵਿੱਚ ਬਗੈਰ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮੁਹੱਈਆ ਕਰਾਉਂਦੇ ਹਾਂ। ਸਾਨੂੰ 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711 'ਤੇ ਟੋਲ ਫ੍ਰੀ ਕਾਲ ਕਰੋ।	*Punjabi*
Вам нужна помощь в получении медицинских услуг, вы хотите поговорить с нами или не можете прочитать присланные вам материалы? Наши материалы можно бесплатно получить на других языках и в другом формате. Позвоните нам по бесплатному телефону 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.	*Russian*
Kailangan mo ba ng tulong sa iyong pangangalagang pangkalusugan, sa pakikipag-usap sa amin, o sa pagbabasa ng mga ipinadala namin sa iyo? Ibinibigay namin ang aming mga materyales sa iba pang wika at format nang wala kang babayaran. Tumawag sa amin nang libre sa 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.	*Tagalog*
Quý vị có cần trợ giúp về dịch vụ chăm sóc sức khỏe, trao đổi với chúng tôi hoặc đọc những tài liệu mà chúng tôi gửi cho quý vị không? Chúng tôi cung cấp miễn phí cho quý vị các tài liệu của chúng tôi bằng các ngôn ngữ và định dạng khác. Hãy gọi cho chúng tôi theo số điện thoại miễn phí 866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 844-284-1797 (Hoosier Care Connect); 833-412-4405 (Indiana PathWays for Aging); TTY 711.	*Vietnamese*

Anthem follows federal civil rights laws. We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important

We offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at **866-408-6131** (Hoosier Healthwise, Healthy Indiana Plan); **844-284-1797** (Hoosier Care Connect); **833-412-4405** (Indiana PathWays for Aging); **TTY 711**.

Your rights

Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail or phone:

Anthem Blue Cross and Blue Shield
Member Appeals and Grievances
P.O. Box 62429
Virginia Beach, VA 23466

Phone: **866-408-6131 (TTY 711)** (Hoosier Healthwise; Healthy Indiana Plan)
844-284-1797 (TTY 711) (Hoosier Care Connect)
833-412-4405 (TTY 711) (Indiana PathWays for Aging)

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the web:** **ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **By mail:** U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F, HHH Building
  Washington, DC 20201
- **By phone:** **800-368-1019 (TTY/TDD 800-537-7697)**

For a complaint form, visit **hhs.gov/civil-rights/filing-a-complaint/index.html**.

anthem.com/inmedicaid

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