



Serving Hoosier Healthwise,
Healthy Indiana Plan
and Hoosier Care Connect

Hoosier Healthwise **Member Handbook**



Welcome and
thank you
for joining
Anthem
Blue Cross and
Blue Shield!

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 **Hoosier Healthwise (HHW)** health care program. We've been honored to serve Hoosier Medicaid members since 2007. Now that you're a part of the Anthem family, we want to make sure you make the most of your benefits.

Inside, you will find:

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

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



Select a doctor and
make an appointment for a
checkup right away.



**Fill out your Health Needs
Screening.** See the flier in
your member packet for details.

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

Thank you again for choosing us as your family's health care plan.

Sincerely,

Kimberly Roop, MD
Plan President



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Hoosier Healthwise Quick Guide

Welcome to your Anthem Blue Cross and Blue Shield Hoosier Healthwise (HHW) 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.



TTY lines are only for members with hearing or speech loss.

Important Phone Numbers



Service	Phone number	Information
Member Services	1-866-408-6131 (TTY 711)	Hours: Monday through Friday, 8 a.m. to 8 p.m. Eastern time. Call for questions about your Anthem health plan, including utilization management, behavioral health, pharmacy and substance abuse services.
24/7 NurseLine — toll-free, 24-hour nurse help line	1-866-408-6131 (TTY 711)	Talk in private with a nurse 24 hours a day, seven days a week. You may also call this line for an interpreter.
Utilization Management (UM)	1-866-408-6131 (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 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.
Anthem Transportation Services	1-844-772-6632 (TTY 1-866-288-3133)	Set up nonemergency rides to the doctor.
National Poison Control Center (Calls are routed to the closest office.)	1-800-222-1222	Talk with a nurse or doctor for free poison prevention advice and treatment 24 hours a day, seven days a week.
Relay Indiana	1-800-743-3333 (TTY 711)	For members with hearing or speech loss, a trained person will help them speak to someone using a standard phone.

Service	Phone number	Information
Vision Service Plan (VSP) (Members in the St. Francis Health Network: Please call your primary doctor.)	1-866-866-5641 (TTY 1-800-428-4833)	Find an eye doctor in your plan or learn more about your vision benefits.
Women, Infants, and Children (WIC)	1-800-522-0874	Learn more about this program, which gives healthy food to pregnant women and young mothers.
Indiana Family and Social Services Administration (FSSA)	1-800-403-0864	Call this number to report any information changes.
HHW Dental Services	1-888-291-3762	Find a dentist or learn more about HHW dental services.
Indiana Tobacco Quitline	1-800-784-8669	Free phone-based service to help smokers quit.
Translation or format services	1-866-408-6131 (TTY 711)	We can translate this handbook in other forms such as Braille, large print or audio CD. Podemos traducir esta informacion sin costo.

Technology at your service

Anthem offers online tools to make it easier for you to access care and services. With our secure member website, you can manage your health care with a few clicks. Just go to our website at www.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.
- 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. Also, check out these Anthem web pages for special programs:

Program	Web Address	Details
Anthem Rewards	www.anthem.com/AnthemRewards	Offers many rewards for staying healthy
Blue Ticket to Health	www.anthem.com/blueticket	Partnership with the Indianapolis Colts so that you can win prizes for getting your wellness checkup



Yes, we have an app for that, too

The Anthem Medicaid mobile app puts your health care at your fingertips. Downloading the app is free on the App Store and Google Play. You can use the app to:

- Find a doctor, hospital or pharmacy in your plan.
- View your claims.
- Check your symptoms.
- Talk with a nurse 24/7 about your health.

Anthem Concierge Unit

Managing health care can be hard. That's why we created the Anthem Concierge Unit. This service can help you:

- Complete your Health Needs Screening.
- Schedule appointments with your PMP.
- Connect to community services like Women, Infants, and Children (WIC).
- And more!

Call 1-866-408-6131 (TTY 711) for the Concierge Unit today.

Has your phone number or address changed?

Let Indiana Family and Social Services Administration know right away. They'll update their records and send the changes to us. To update your phone or address, you can:

- Call 1-800-403-0864.
- Visit your local Division of Family Resources (DFR) office.
- Go to www.in.gov/fssa. Under *Online Services*, click the **Apply for Services** button and then **Apply for Benefits online**. Follow the steps for submitting changes in your information tab.

A quick look at your HHW benefits

With Anthem, you have access to:

- | | | |
|--------------------------|-----------------------------|--------------------------------|
| • Doctor care. | • Therapy services. | • Vision services. |
| • Chiropractic services. | • Behavioral health. | • Podiatry services. |
| • Hospital care. | • Smoking cessation. | • Nonemergency transportation. |
| • Medical supplies. | • Skilled nursing facility. | |

Extra benefits

In addition to your HHW benefits, and many doctors to choose from, Anthem offers you these extras:



Extra Benefits	Details
Cellphone	Limited to one per household: <ul style="list-style-type: none">• 350 minutes each month• Unlimited texting• One-time bonus of 200 minutes
Home-delivered meals	Up to five days after your hospital visit: <ul style="list-style-type: none">• For members discharged for post-operative recovery or new mothers with babies from the neonatal intensive care unit• One meal per day for five days• Contact your case manager
Pregnancy tests	Limit three per year: <ul style="list-style-type: none">• Must have prescription• Must be Equate-brand or CVS-brand tests
Boys & Girls Club	Memberships for positive youth development: <ul style="list-style-type: none">• For school-aged children• Call Member Services to request a letter
Healthy Families	Program to help overweight children live healthier lives: <ul style="list-style-type: none">• Six-month coaching session by phone• For ages 7 to 13• One-time lifetime benefit
Hypoallergenic bedding	Must have referral from your provider/case manager
Dental hygiene kits	Includes: <ul style="list-style-type: none">• Toothbrush kit• Toothpaste• Dental floss• Dental health information
Community Resource Link	Resources in your area that support health and wellness <ul style="list-style-type: none">• Visit www.anthem.com/inmedicaid and go to Community Support

Extra Benefits	Details
Health and wellness magazines	One-year subscription, compliments of Anthem, to: <ul style="list-style-type: none"> • <i>Parents</i> • <i>Diabetic Living</i> • <i>EatingWell</i>
Nonemergency transportation	<ul style="list-style-type: none"> • Rides at no cost to: • Your doctor's office • WIC offices • Benefit renewal appointments • Call Anthem Transportation Services at 1-844-772-6632 (TTY 1-866-288-3133) to set up rides

Some of these extra benefits are limited to certain members. To find out which benefits you may qualify for, call Member Services at 1-866-408-6131 (TTY 711). Benefits may change or end at any time.

For complete benefits, see the *Services offered by Anthem* section in Part 1.

Hoosier Healthwise benefit plans

There are three Hoosier Healthwise (HHW) benefit plans Anthem provides access to.

1. **Package A:** children and pregnant women
2. **Package C:** children under 19 who don't qualify for Package A
3. **Package P:** pregnant women who are presumptively eligible for Medicaid
4. **HIP Maternity:** pregnant women who qualify for the Healthy Indiana Plan (HIP) Please refer to Part 1 for more details. If you have any questions about benefits, call Member Services at 1-866-408-6131 (TTY 711).

Ways to good health

Follow these easy steps to begin, manage and maintain good health.

- **Choose a doctor** — Your primary medical provider (PMP) is the first person you call for your health care needs.
- **Take the Health Needs Screening** — It helps us get the right care for you. You can earn \$10! See the *Anthem Rewards Program* section in this *Quick Guide* for details.
- **Schedule a health checkup** — Call your PMP's office to make an appointment. Get annual checkups even if you do not feel sick. This will help you maintain good health.
- **Prepare for your doctor's visit** — Decide what you want to discuss and write it down. Be ready to talk about your health history.
- **Keep your member ID card close** — Show it every time you need health care services.

Pharmacy services

When you need medicine or certain over-the-counter (OTC) items, your doctor writes you a prescription. You can then go to any Anthem plan pharmacy, including mail-order pharmacies. To find a pharmacy, call 1-866-408-6131. Or go to www.anthem.com/inmedicaid.



The Anthem Rewards program

This is Anthem's way of rewarding members who take steps toward good health. As an Anthem member, you'll get rewards for completing healthy activities. You can use these rewards to make purchases at Walmart.

The first reward is for completing the Health Needs Screening (HNS) within 90 days of joining Anthem. You can complete the HNS and earn your rewards in one of three ways:

- At your local Walmart Pharmacy kiosk
- Online at www.anthem.com/HNS
- Or by calling 1-866-408-6131 (TTY 711)

New Anthem members will receive more details about completing the HNS and other healthy activities. Go to www.anthem.com/AnthemRewards to find out what other rewards you may be able to earn.

Blue Ticket to Health — Get in the game

There's a new game in town — it's called **Blue Ticket to Health!** Anthem has teamed up with the Indianapolis Colts to help members age 3 and up be healthy. To take part, call your doctor to set up a wellness checkup. After you complete your checkup, you'll be entered for a chance to win one of over 500 prizes, including tickets to Colts home games, stadium tours and more. Go to www.anthem.com/blueticket to learn more.

It's important to see the doctor each year for wellness checkups, even when you're not sick. It helps the doctor find any health problems early. If you need help setting up a wellness checkup, call Member Services.

Community Resource Link

We provide you access to online resource tools, like the Community Resource Link, to help you find and apply for community and social services in Indiana. Find these services in your area by visiting www.anthem.com/inmedicaid.



Urgent care or emergency room (ER)

When you're sick or hurt, check the list of symptoms to see where you should go for care. If you need help on which to choose, call our 24/7 NurseLine at 1-866-408-6131 (TTY 711).

Urgent care symptoms:

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

ER symptoms:

- Chest pain, difficulty breathing
- Head and eye injuries
- Uncontrolled bleeding, severe cuts
- Bad broken bone
- Coughing or vomiting blood
- Bleeding during pregnancy
- Baby under eight weeks with fever
- Rash with fever

Your primary medical provider

Your primary medical provider (PMP) is the first person you should call for your health care needs. Your PMP coordinates things like:

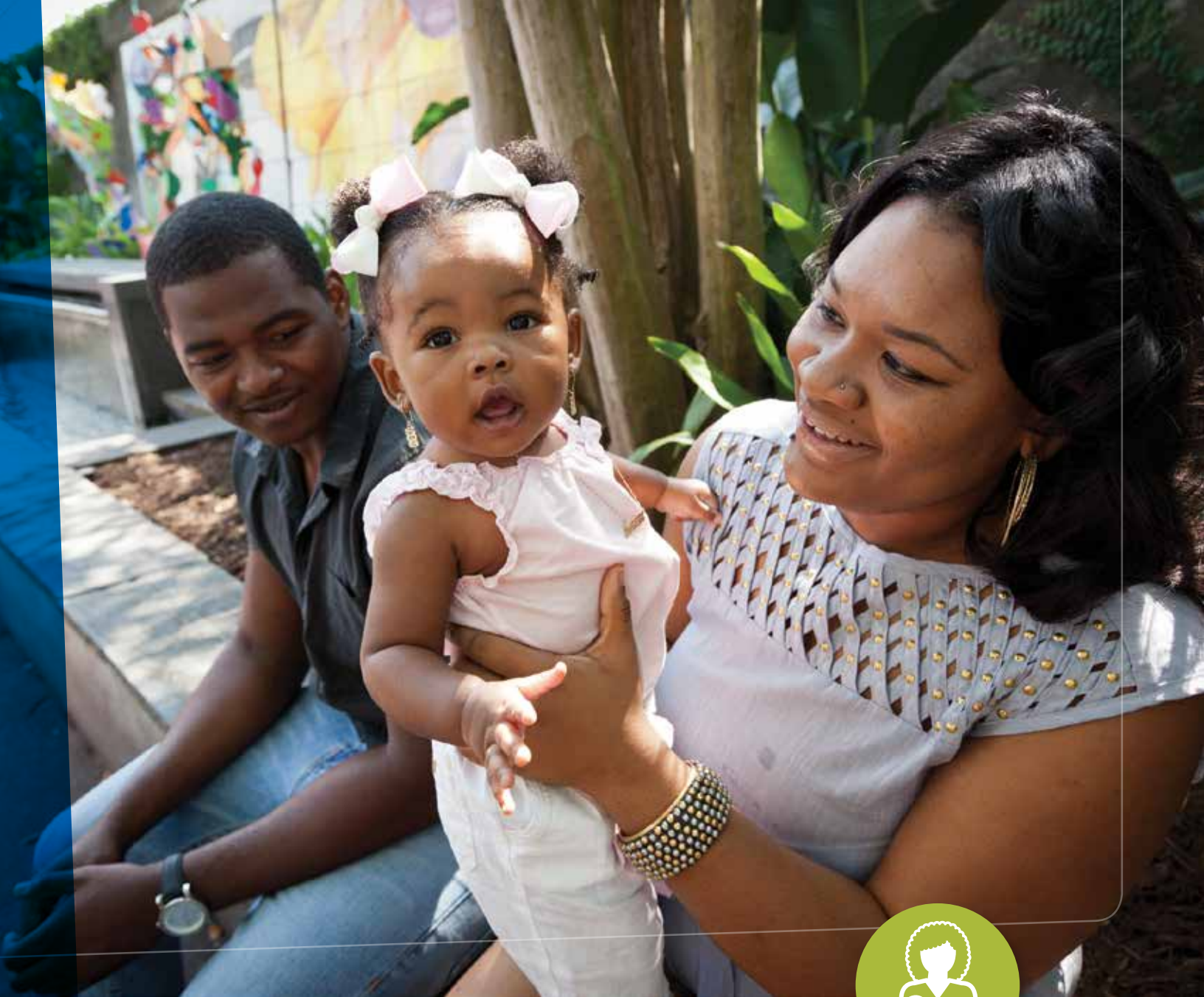
- Checkups and vaccines
- Referrals to specialists
- Referrals for tests and services
- Admission to a hospital

Keep your health care

When you enroll in Hoosier Healthwise (HHW), you're eligible for 12 months. Then, you have to apply for your benefits again. This is known as **redetermination**. The state will send you a letter when it's time to re-enroll.

Here's what happens:

- About 90 days before the end of your 12-month enrollment period, the state will see if you're still eligible for HHW.
- If the state doesn't have enough information, they'll ask you for more information.
- You must complete and return the requested information to stay enrolled in HHW.



Part 1 – All about Hoosier Healthwise

Hoosier Healthwise (HHW) is Indiana's Medicaid plan for pregnant women and children. Anthem provides access to three benefit plans for HHW members, including:

1. **HHW Package A:** for children and pregnant women
2. **HHW Package C:** preventive, primary and acute care services for children under 19 years of age who don't qualify for Package A

3. **HHW Package P:** for women who are found to be presumptively eligible (PE) for Medicaid; to qualify for HHW Pregnancy PE status, you must:

- Be pregnant, as verified by a pregnancy test done by a health care professional.
- Be an Indiana resident.
- Be a U.S. citizen or qualified noncitizen.
- Not be a current HHW member.
- Not be in prison.
- Have a gross family income less than 200 percent of the federal poverty level.

Package P doesn't include inpatient services, but Anthem will pay if the woman is a HHW member and it's medically necessary.

Prenatal and postpartum programs

Anthem offers many programs and rewards to help members before and after their pregnancy.

New Baby, New LifeSM

Once you let us know you are pregnant, you are enrolled in the New Baby, New LifeSM program. We'll send you information on how to take care of yourself during pregnancy and how to prepare for your new baby. After giving birth, you will receive information about self-care and care for your newborn. If you need extra support, you can speak to a case manager who will guide you along the way.

Through this program, you can get:

- Rewards for going to your prenatal and postpartum appointments.
- Helpful information.
- Tips, appointment reminders and videos at no cost to you
 - **My Advocate[®]**. Visit www.MyAdvocateHelps.com or call Member Services
 - Text4baby — Text BABY to 511411. When prompted, enter your due date and ZIP code. To learn more, visit www.Text4Baby.org.



For more information about our prenatal programs, call Member Services at 1-866-408-6131 TTY (711).

Prenatal rewards

If you're pregnant, you could be rewarded for getting the needed prenatal and postpartum care for you and your baby. To learn more, call Member Services toll free at 1-866-408-6131 (TTY 711) to receive information on our prenatal rewards.

CenteringPregnancy®

CenteringPregnancy® is a peer support group, offering women a place to share their feelings and concerns during their pregnancy. A group facilitator guides the discussion and introduces new points of view.

Baby shower program

Anthem partners with groups, such as WIC, to host baby showers around the state to educate pregnant women about their babies. There, you can learn about the importance of well-baby visits, how to select a doctor, schedule appointments and more.

Baby and Me Tobacco Free

This smoking-cessation program aims to lower the tobacco use of pregnant women. Those who follow these four steps will be eligible for rewards, such as \$25 diaper vouchers:

1. Enroll in the program
2. Take prenatal smoking-cessation classes
3. Agree to take a monthly breath test
4. Stay smoke free after their baby is born

Go to www.babyandmetobaccofree.org to find out more.



Services Anthem covers

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



Benefits	Details	Copay
Doctor care	Includes: preventive care, physical exams, prenatal care, well-child checkups, immunizations, specialty care	None
Chiropractic services	<p>Package A: up to five visits per year and 50 therapeutic physical medicine treatments per year</p> <p>Package C: up to five visits per year and 14 therapeutic physical medicine treatments in a rolling 12-month period</p>	None
Hospital care	Includes: emergency room, inpatient services, outpatient services and surgeries, lab tests and X-rays, post-stabilization services, ambulance rides for emergencies	Package C: \$10 for ambulance transport
Medical supplies	Includes: diabetes supplies, durable medical equipment, hearing aids, orthopedic shoes and leg braces, orthotics, and prosthetic devices	None
Therapy services	<p>Physical, speech, occupational and respiratory therapy</p> <p>Package C: maximum of 50 visits for each therapy type, per 12-month period</p>	None
Pharmacy		<p>Package C: \$3 generic drugs, \$10 brand-name drugs</p> <p>You don't have copays if you're:</p> <ul style="list-style-type: none"> • Under 18 years old. • Getting pregnancy or family planning services. • Getting services in the ER, hospital or nursing home.

Benefits	Details	Copay
Behavioral health	Services for mental health and substance abuse	None
Smoking cessation	Includes: <ul style="list-style-type: none"> One 12-week course of treatment percalendar year Prescription and over-the-counter treatment, such as nicotine patches or gum Counseling services (a limit of eight hours of counseling services) 	None
Skilled nursing facility	Package A: up to 30 days per rolling 12-month period Package C: not offered	None
Vision services	Package A Exams for members: <ul style="list-style-type: none"> Under 21: One per year 21 years and up: One every two years, unless more frequent care is medically necessary. Glasses (including frames and lenses) for members: <ul style="list-style-type: none"> Under 21: One pair per year 21 years and older: One pair every 5 years Contact lenses, if medically necessary Package C Exams for members: <ul style="list-style-type: none"> Under 21 years: One exam every 12 months Glasses (including frames and lenses): One pair per year, except when a specific minimum prescription change makes it medically necessary, or if lenses and/or frames are lost, stolen or broken. Contact lenses, if medically necessary 	None

Benefits	Details	Copay
Podiatry services	Package A: up to six routine foot care visits per year Package C: routine foot care is not offered	None
Nonemergency transportation	Package A: unlimited trips to any approved medical, behavioral health, dental and vision appointment Package C: up to 20 one-way trips each year and up to 50 miles each way Anthem also allows trips: <ul style="list-style-type: none"> • For those enrolled in the Women, Infants, and Children (WIC) program. • To the Division of Family Resources (DFR). • To health education programs. 	Package A: No copay Package C: \$10 copay for nonemergent ambulance transportation; \$10 copay for emergent and nonemergent transportation

Other services

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

Carve-out services include:

- Medicaid Rehabilitation Option (MRO)
- Individualized Education Plan Services
- Individualized Family Services Plan (First Steps)
- 1915i Waiver wrap around services



See the *Extra Benefits* section in the Quick Guide in front of the handbook to learn more about all the extras Anthem offers!



What is post-stabilization?

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.

Services not covered by Anthem include:

- Services that are not medically necessary
- Nursing home (for more than allowed under plan benefits) or long-term care facility services
- Intermediate Care Facility Services (ICF/MR)
- Services under the Home- and Community-based Services (HCBS) waiver
- Psychiatric state hospital or residential treatments
- Services/care you receive in another country
- Acupuncture
- Experimental or investigational treatments
- Cosmetic surgery (this does not apply to reconstructive surgery)
- Alternative medicine
- Surgery or drugs to help you get pregnant
- Sex change surgery or treatments
- Vitamins, supplements and over-the-counter (OTC) medicines not offered through the pharmacy benefit
- OTC birth control
- Personal attendant nursing services
- Any condition, disease, defect, ailment or injury that takes place while working if you have workers' compensation
- Hospice — members who need hospice services must disenroll from Anthem HHW and enroll in traditional Medicaid

Services from doctors who are not in 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 may be able to see this out-of-plan doctor for a self-referral. See *Self-referral services* below for more details. 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.

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

Self-referral services

You can receive self-referral services for any of these services below without seeing your PMP. You can visit any Indiana Health Coverage Programs (IHCP) provider. Remember to talk to your PMP about all your health care needs:

- Dental services
- Behavioral health
- Chiropractic care
- Diabetes self-care training
- Emergency services
- Urgent care
- Eye and vision care
- Family planning
- HIV/AIDS care management
- Podiatry services
- Immunizations





What are some good daily dental tips?

To maintain good oral health, brush twice a day and floss daily.

Dental benefit summary

HHW offers the routine dental care you need to keep you healthy, including:

- Exams
- Cleanings
- X-rays
- Fillings
- Fluoride treatment (age 20 and under)
- Crowns
- Extractions

If you get into an accident and hurt your jaw, mouth, face or teeth, you'll receive dental work and oral surgery for these services:

- Outpatient
- Doctor office
- Emergency care
- Urgent care

Note: This does not apply to care for temporary mandibular joint (TMJ) disorders or injury due to chewing or biting.

To find out more about your dental benefits, call DentaQuest at 1-888-291-3762.

Vision benefit summary

Package A

Exams for members:

- Under 21: One per year
- 21 years and up: One every two years, unless more frequent care is medically necessary.
- Glasses (including frames and lenses) for members:
 - Under 21: One pair per year
 - 21 years and older: One pair every 5 years
 - Contact lenses, if medically necessary

Package C

Exams for members:

- Under 21 years: One exam every 12 months
- Glasses (including frames and lenses): One pair per year, except when a specific minimum prescription change makes it medically necessary, or if lenses and/or frames are lost, stolen or broken.
- Contact lenses, if medically necessary



Part 2 – Ways to good health

Choose your primary medical provider (PMP)

Your PMP is the first person you call for all your health care needs. He or she 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 health care 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 or general practitioner, a doctor who takes care of babies, children, and adults.
- Internist, a doctor who takes care of adults.
- Obstetrician/gynecologist (OB/GYN), a doctor who takes care of women only.
- Doctors at clinics such as health departments, federally qualified health centers and rural health clinics.
- Nurse practitioner, a nurse who works with your PMP.
- Pediatrician, a doctor who takes care of members under age 21.

To select a doctor, or PMP, you can:

- Look inside Anthem's provider directory to find and choose a PMP. To choose a St. Francis doctor, use St. Francis Hoosier Healthwise (HHW) plan.
- Go online at www.anthem.com/inmedicaid and click on *Find a Doctor*.
- Call Member Services at 1-866-408-6131 (TTY 711).



How do I find out more about PMPs?

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, call Member Services at 1-866-408-6131 (TTY 711).

Services from doctors who are not in the Anthem plan

Call your PMP or Member Services to find out if you need an OK from a doctor who isn't in your plan. We can only give an OK for doctors that are part of your plan.

If you get a service from a doctor that is not in our plan or the service is not approved, it'll be considered out-of-plan service. This doesn't apply to some self-referral services. You may be able to see a doctor who is not in our plan for self-referral.

Are there other times I should visit my PMP?

You should visit your doctor once a year for a checkup — even if you don't feel sick. To help you remember, schedule your checkup in the same month as your birthday each year.



Continuity of care

We're here to help new members get continuing care and coordination of medically necessary health care when they join Anthem. If you want to know if continuity of care is for you, call Member Services at 1 866-408-6131 (TTY 711).

Changing from pediatric care to adult care

Did you know you can switch doctors when you get older? If you were an adolescent and reached adulthood, you can switch from your current pediatrician (child doctor) to a provider who cares for adults. We'll be happy to help you choose a provider for adults. We can also help you transfer your medical records. Please call Member Services.

Schedule a health checkup

Call your PMP's office to make an appointment for a checkup. Tell them you're an Anthem member. When you make an appointment with your PMP to get a checkup, your PMP will:

- Get to know you and discuss your health.
- Get your medical history from you.
- Help you understand your medical needs.
- Teach you ways to help make your health better or help you stay healthy.
- Schedule any needed tests and preventive services.

Hoosier HealthWatch — Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

For children up to 21 years of age, we offer EPSDT services. You can help keep your child healthy if:

- You take them to their primary medical provider (PMP) for routine checkups and vaccines (shots).
- You take them to the dentist for routine visits.

Anthem follows the guidelines from the American Academy of Pediatrics for well-child visits. These steps will help keep your children healthy and strong. This chart shows when children should visit the doctor for a well-child visit.

Important child wellness visits

Track your child's growth and development. Don't forget important vision and hearing tests and shots. Check off each child wellness visit when completed.

Baby	
1 week	
1 month	
2 months	
4 months	
6 months	
9 months	

Early childhood	
12 months	
15 months	
18 months	
2 years	
30 months	
3 years	
4 years	

Middle childhood	
5 years	
6 years	
7 years	
8 years	
9 years	
10 years	

Teen (Adolescent)	
11 years	
12 years	
13 years	
14 years	
15 years	
16 years	
17 years	
18 years	
19 years	
20 years	
21 years	

Lead screening	
12 months	
24 months	

Dental visits	
By baby's first tooth appearance and no later than 12 months	

Protect your family from lead poisoning

All children enrolled in Medicaid must have a blood lead level (BLL) test at both 1 and 2 years of age. They must take a BLL test at least once by age 6 or if they are at risk. If you check one or more of the boxes below, your child must take a BLL test right away.

Does your child:

- ☐ Visit or live in a house built before 1978 (such as the home of a relative or babysitter, a day care center or a preschool)?
- ☐ Visit or live in a house built before 1978 that is being or will be remodeled?
- ☐ Have a brother, sister or friend who has had lead poisoning?
- ☐ Visit or live in a house that has chipping, peeling, dusting or chalking paint?
- ☐ Often visit an adult who works with lead (such as pottery, painting, construction or welding)?

See the *Preventive Health Guidelines* on www.anthem.com/inmedicaid to learn more about wellness visits and shots.

Prepare for your doctor's visit

- Decide what you want to talk about and write down your questions or concerns.
- Be prepared to talk about you and your family's health history.
- Bring a list of any medications you're taking or bring them with you.
- Check your current medications and make sure you're taking them correctly.



Remember these three things for your member ID

1. **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 health care.
2. **Show this ID card every time you need health care services.** Only you can get health care services with your ID card. Don't let anyone else use your card.
3. **If you lose your card, ask for a replacement card.** Log in at www.anthem.com/inmedicaid. Or you can call 1-866-408-6131 (TTY 711).

Preapproval (an OK from Anthem)

Your PMP will need to get an OK from us for some services to make sure they're offered. This means that both Anthem and your PMP or specialist agree the services are medically necessary. We may ask your doctor why you need special care.

Getting an OK will take no more than seven calendar days or, if urgent, no more than three days.

We may not OK payment for a service you or your doctor asks for. If so, we'll send you and your doctor a letter that explains why. The letter will let you know how to appeal our decision if you disagree with it. See the *Appeals* section in Part 6.

If you have questions, you or your doctor may call us at Member Services or see *Important phone numbers*. Or write us at: Anthem Blue Cross and Blue Shield, P.O. Box 62509, Virginia Beach, VA 23466

Changing your PMP

It's best to keep the same PMP. He or she knows your health needs. If you choose to see a doctor who is not your PMP without 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 www.anthem.com/inmedicaid. 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 clicking *Register*. You'll need your member ID number located on your ID card.

Specialist care

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 not need an OK from us. Your PMP knows when to ask for an OK. Your PMP's office staff can help you. They can set the day and time for the office visit with a specialist. Tell your PMP and the specialist as much as you can about your health. Any specialist or other provider not in the Anthem health plan must get an OK from us before they can give you care. You may also need a referral from your PMP.

Standing referral

Anthem sometimes lets members get what's called a standing referral. This means if you need special care or ongoing treatment, you can keep seeing the same specialist. Your doctor will make this referral. The treatment given by the specialist must be right for your health issue and needs. To learn more about this, call Member Services at 1 866-408-6131 (TTY 711).

Getting a second opinion

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 1 866-408-6131 (TTY 711).

Indiana Right Choices program

If you're enrolled in this program, we'll send you a letter to let you know. A team of experts will help you get the right health care at the right time in the right place. Your team will be made up of a PMP, a pharmacy, a hospital and a care manager. If you have questions about the Right Choices program, call Case Management at 1-866-902-1690.

Behavioral health services

We offer services for mental health, behavior problems and addiction. You don't need a referral from your PMP to see someone for these services. Anthem covers inpatient services in a hospital, partial hospitalization, intensive outpatient program, individual, family and group therapy, applied behavior analysis, medication services and psychological testing. We can help you find a doctor in your area.

Stay well

Each person has special needs at every stage of life. We have programs to help you stay healthy and manage illness. These programs are available to all members at no cost.

For women

- Well-woman care includes getting exams such as annual checkups, mammograms and cervical cancer screenings.
- Family planning can teach you about healthy pregnancy, preventing pregnancy or preventing sexually transmitted infections (STIs) such as HIV/AIDS. You can get family planning services from your PMP, a clinic, OB/GYN or a certified nurse-midwife.
- Pregnancy and childbirth classes to help you stay healthy while you're pregnant.
- 24/7 NurseLine provides support for moms-to-be and new mothers who have questions about breastfeeding.



For you and your child

- Well-child care includes programs to help you keep your child well. You can learn about healthy habits for your child, the need for regular doctor visits and which vaccines your child needs. You can also earn incentives by taking your child to wellness checkups.
- We offer parenting tips to teach you how to care for your child.

A 24/7 line for your peace of mind

The 24/7 NurseLine lets you talk in private with a registered nurse (RN) about your health. Teens can talk to RNs in private about teen issues. Just call 1-866-408-6131 (TTY 711).



Case management

Health care can be overwhelming, so we're here to help you stay on top of it. Your case manager will help you:

- Figure out your care plan.
- Answer questions.
- Get you to the services you need.
- Coordinate with your doctors and support system.



If you've 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.

Access to complex case management

We use data to find out which members qualify for our complex case management program. You can be referred to complex case management through our:

- Medical management program referral.
- Discharge planner referral.
- Member or caregiver referral.
- Practitioner referral.

If you have one of these health issues or another complex or special health issue and want to learn more about case management, call Case Management at 1-866-902-1690.

Healthy Families program

The Healthy Families program is a six-month coaching program for members with children who are overweight. Members receive tips over the phone to help them focus on healthy lifestyle choices. The program involves:

- A family-focused approach.
- Many levels of support through the family and community.
- Resources you can find online.

Educational materials

You can find **Health Tips**, an information sheet with helpful ways to stay healthy, on our website at www.anthem.com/inmedicaid. We also offer quarterly newsletters with information on specific health-related topics, the importance of preventive care and how to navigate the health care system.

Indiana Quitline

When you're ready to quit, just call the Indiana Tobacco Quitline at 1-800-Quit-NOW or 1-800-784-8669 for more information. This service is free for all Indiana residents. Call Member Services at 1-866-408-6131 (TTY 711) to find out more about signing up for the Quitline. If you're pregnant, you may be able to earn rewards.

Providers, nurses, social workers and members or their representative may refer you to case management in one of two ways:



Phone: 1-866-902-1690

Fax: 1-855-417-1289 (TTY 711)

A case manager will respond to a faxed request within three business days.

Disease management

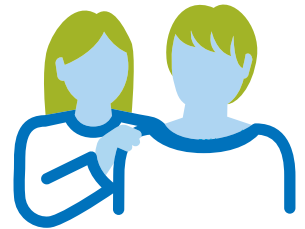
Our disease management program helps guide care for our members with chronic health conditions. The program is voluntary, private and available at no cost to you from the Disease Management Centralized Care Unit (DMCCU) team. Our team of licensed nurses, called DMCCU case managers, will help you understand your condition and help you meet health care goals through education, resources, and referrals to providers for care.

You can join the program if you have one of these conditions:

- Asthma
- Pregnancy
- ADHD
- Autism/Pervasive developmental disorder
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Chronic kidney disease
- Congestive heart failure (CHF)
- Hypertension
- Diabetes
- HIV/AIDS
- Major depressive disorder
- Schizophrenia
- Bipolar disorder
- Substance use disorder

Our case managers assist with weight management and smoking cessation services. As a member in the disease management program, you'll benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs.
- Helps you make a care plan to reach your health care goals.
- Gives you the tools, support and community resources that can help you improve your quality of life.
- Provides health information that can help you make better choices.
- Helps you coordinate care with your providers.



As an Anthem member enrolled in the DMCCU program, you have certain rights and responsibilities. You have the right to:

- Have information about Anthem; this includes all Anthem programs and services as well as our staff's education and work experience; it also includes contracts we have with other businesses or agencies.
- Refuse to take part in or leave programs and services we offer.
- Know who your case manager is and how to ask for a different case manager.
- Have Anthem help you to make choices with your doctors about your health care.
- Learn about all DMCCU-related treatments; these include anything stated in the clinical guidelines, whether covered by Anthem or not; you have the right to talk about all options with your doctors.

- Have personal data and medical information kept private.
- Know who has access to your information and know our procedures used to ensure security, privacy and confidentiality.
- Be treated with courtesy and respect by Anthem staff.
- File complaints to Anthem and get guidance on how to use the complaint process, including how long it will take us to respond and resolve issues of quality and complaints.
- Get information that is clear and easy to understand.

You are encouraged to:

- Follow health care advice offered by Anthem.
- Give Anthem information needed to carry out our services.
- Tell Anthem and your doctors if you decide to disenroll from the DMCCU program.

If you have one of these health issues or would like to know more about our DMCCU, please call **1-888-830-4300** Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Ask to speak with a DMCCU case manager. Or you can leave a private message for your case manager 24 hours a day. You can also visit our website at www.anthem.com/inmedicaid and select **Manage Your Condition** under the **Care** tab. or call the DMCCU if you would like a copy of DMCCU information you find online. Calling can be your first step on the road to better health.

Healthy Family Lifestyles program

Healthy Family Lifestyles is a six-month program for ages 7-17, designed to assist families in obtaining a healthier lifestyle. This program provides families with fitness and healthy behavior coaching, written nutrition information, and online and community resources. For additional information or to enroll in the Healthy Families program, call us at 1-888-830-4300.

Autism spectrum disorders program

Families touched by autism can speak with counselors from our autism spectrum disorders (ASD) program. We offer a support system to help families understand about the care that's available. Our goal is to help children with ASD live a healthier life with their families.

Autism Family Supports program

Anthem and the Indiana Easterseals are proud to offer the Autism Family Supports program for members with moderate-to-severe autism spectrum disorder (ASD). We coordinate care with the member's PMP, physical and behavioral specialists, as well as schools and social services to fully support the member.

The Autism Family Supports program helps members with:

- Care planning.
- Developmental skills.
- Health promotion activities.
- Disease management programs.
- Transition support

Substance use disorder program

Anthem's substance use disorder (SUD) program helps members with major substance use disorder improve their overall health. Our care managers work with you to identify long-term goals, helping you attain a healthier lifestyle.

Human immunodeficiency virus (HIV) rewards program

For those with HIV, it's important to continue taking your medication to help lower levels of the virus in the body. It also allows you to live longer and reduces the spread of the virus. To support our members in this population, we're offering rewards to those who continue taking their medications and having regular lab tests. You can earn \$25 per quarter for up to two quarters per year — a \$50 maximum yearly reward.

Depending on your condition, you may be enrolled in our HIV management program. If you have HIV and a substance use disorder, you'll be referred to our substance treatment services. For those with a greater need, we'll help coordinate care for you.

Urgent or emergency care? Which do I choose?

Go to the *Quick Guide* and check the *Urgent care or emergency room (ER)?* section for a list of symptoms.



WebMD's Personal Health Record

We've partnered with WebMD Health Services to provide WebMD's Personal Health Record (PHR). WebMD's PHR will serve as a bank of your health information, using Anthem's clinical data and health information you add. By giving you the information you need in one place, you'll be able to make better decisions about your benefits, treatment and doctors in your plan.

Sick or hurt? Where do you go?

After-hours care

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 can't reach your PMP, call our 24/7 NurseLine, even on holidays, at 1-866-408-6131 (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 the 24/7 NurseLine if you have questions.

Emergency care

An emergency is a medical condition with such severe symptoms that you reasonably believe not getting medical attention right away may be life threatening or cause serious damage to you or your unborn child. If you have an emergency, call 911 or go to the nearest ER.

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.

Getting 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 get the help you need:

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



Part 3 – Pharmacy services

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 Express Scripts 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 1-866-408-6131.
- Your pharmacy benefits have a Preferred Drug List (PDL). The PDL shows some of the drugs offered under the pharmacy benefit. Find the complete PDL list at www.anthem.com/inmedicaid.

Anthem doesn't offer these prescription drugs

- Over-the-counter (OTC) medicines (unless specified on the formulary or PDL list)
- Drugs used to get pregnant
- 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:

- By law, 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.

Pharmacy copays

- **Package C:** \$3 for generic drugs and \$10 for brand-name drugs

If you have questions, call Member Services at 1-866-408-6131, Monday through Friday from 8 a.m. to 8 p.m. Eastern time.



Preapproval for drugs

Some drugs need a preapproval ahead of time. Your doctor must ask for a preapproval 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 drugs than what is normally expected.
- There are other drugs that should be tried first.

If a preapproval 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.



See your ID card for the phone number for preapproval requests.

IHCP or Anthem will decide if your drug request can be approved within 24 hours after getting your request (not including Sundays or some holidays). Your doctor will be notified.

Other things you need to know about your medication

Days' supply of drugs

Drugs you take for a long time have a 100-day supply limit. Drugs you take for a shorter time have a 30-day supply limit.

Early refills

Your pharmacist will have to ask for an OK ahead of time if you want to get your prescription refilled early. Do not wait until you're out of a drug to ask for a refill. Please call your doctor or pharmacy a few days before you run out of your drug.

Emergency safety programs

Through Emergency Safety Communications, we alert you and your doctors about significant safety-related drug recalls or market withdrawals.

Member medication support

To support members who've recently visited the emergency room, we send surveys to gather information about your experience and reasons for the visit. If your visit was related to a medication issue, we'll send a letter about the medications and how to appropriately take them.

Appeal rights

If your drug request is denied, you or your provider can appeal this decision. You may ask for a Medicaid hearing and appeal review if IHCP or Anthem:

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

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

FSSA Hearing and Appeals

RM E034 — IGC-S, MS04

402 W. Washington St.

Indianapolis, IN 46204

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





Part 4 – Help with special services

Help in other languages

We offer no-cost services and programs that meet many language and cultural needs. We also help give you access to quality care and connect you to information about benefits. We use an interpreter service that works with more than 140 languages. We offer:

- Health education materials translated into different languages.
- Member Services staff able to speak other languages.
- 24-hour access to telephone interpreters.
- Sign language and face-to-face interpreters.
- Doctors who speak other languages.
- Translation for you while you're at your primary medical provider's (PMP's) office.

Call Member Services at least 72 hours in advance if you need an interpreter or translator at your PMP's office.

Help for members with hearing or vision loss

Call our toll-free Member Services line at 1-866-408-6131 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m., Eastern time. If you need help to understand your benefits between 8 p.m. and 7 a.m. or on weekends, call Relay Indiana at 1-800-743-3333 (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 1-866-408-6131 (TTY 711).



When did the ADA become law?

The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990, by President George H. W. Bush. The 25th anniversary of the ADA was celebrated in 2015.



Part 5 – Know your rights and other helpful information

Member rights

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

- Receive information about Anthem, the services we provide, doctors and facilities in your plan and your rights and responsibilities. You can find information about Anthem on our website at www.anthem.com/inmedicaid. You can also call Member Services at 1-866-408-6131 (TTY 711).
- 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 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 health care. This includes the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal laws on the use of restraints and seclusions.
- Request and receive a copy of your medical records. And you may request they be amended or corrected, as stated in state and federal health care privacy laws.
- Have timely access to approved services and medically-necessary care.
- Have honest talks with your doctors about the right treatment for your condition, in spite of the cost.
- Have your health plan, doctors and all of your care providers keep your medical records and health insurance information private.
- Have your problems taken care of fast. (This includes things you think are wrong, as well as issues that have to do with your benefits, payment of services or getting 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.
- Get interpreter services at no charge if you speak a language other than English or if you have hearing, vision or speech loss. Ask for information and other Anthem materials (letters, newsletters) in other formats. These include Braille, large-size print or audio CD, at no charge to you. Call Member Services at 1-866-408-6131 (TTY 711).
- Tell us what you would like to change about your member rights and responsibility 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.
- Ask about our quality program and tell us if you would like to see changes made.
- Ask us how we do utilization review and give us ideas on how to change it.
- Know you will not be held liable if your health plan becomes insolvent (bankrupt and cannot pay its bills).
- Know that Anthem, your doctors or your other health care providers cannot treat you differently for these reasons:
 - Your age
 - Your sex
 - Your race
 - Your national origin
 - Your language needs
 - The degree of your illness or health condition



Member responsibilities

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

- Tell us, your doctor and your other health care providers what they need to know to treat you.
- Understand your health problems and take part in developing shared treatment goals, to the best degree possible.
- Follow the treatment plans you, your doctors and your other health care providers agree to.
- Do the things that keep you from getting sick.
- Treat your doctor and other health care providers with respect.
- Make appointments with your doctor when 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 get medical care.
- Use the emergency room only for true emergencies.
- Pay any required copays.
- Tell us and your social worker if:
 - You move.
 - You change your phone number.
 - You have any changes to your insurance.
 - The number of people in your household changes.
 - You become pregnant.

Making benefit decisions

At Anthem, we care about you and want to help you get the health care you need. We do not give incentives for service denials and we only make decisions based on appropriateness of care and available benefits. Your doctors and other health providers work with you to decide what's best for you and your health. Your doctor may ask us for our OK to pay for a certain health care service.

We base our decision on two things:

- Whether or not the care is medically necessary.*
- What health care benefits you have.

We do not pay or reward doctors or other health care workers to:

- Deny you care.
- Say you do not have benefits.
- Approve less care than you need.

* Medically necessary means Anthem will pay for services needed to:

- Protect your life.
- Keep you from getting seriously ill or disabled.
- Reduce severe pain through the diagnosis or treatment of disease, illness or injury.



New medical treatments

We want you to benefit from new treatments, so we review them on a routine basis. A group of PMPs, specialists and medical directors decide if a treatment:

- Is approved by the government.
- Has shown in a reliable study how it affects patients.
- Will help patients as much as, or more than, treatments we use now.
- Will improve the patient's health.

The review group looks at all of the details. The group decides if the treatment is medically necessary. If your doctor asks us about a treatment the review group has not looked at yet, the reviewers will learn about the treatment. They'll let your doctor know if the treatment is medically necessary and if we approve it.

Choosing a new health plan

HHW members may change to a different doctor for any reason during the first 90 days of membership. If you have questions about changing your health plan, call Member Services. You may also call the Hoosier Healthwise Helpline at 1-800-899-9949.

You can also change health plans "for cause" at any time if:

- You receive poor quality of care or if there are other times that are determined to be poor quality of care.
- We cannot provide approved services.
- We fail to comply with certain medical standards and practices.
- There is a lack of access to providers experienced in dealing with your health care needs.
- There are major language or cultural barriers.
- Anthem is going through a corrective action.
- You have limited access primary care clinic or other health services near you.
- Another managed care entity (MCE) has a formulary (list of drugs) that's better for your health care needs.
- You don't have access to medically necessary services Anthem pays for.
- A service is not paid for 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 plan, and your provider says getting the services separately will be a risk to you.
- Your PMP disenrolls from Anthem and re-enrolls with another MCE.
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

If you have a question about changing your health plan, call Member Services. You also may call the Hoosier Healthwise Helpline at 1-800-889-9949.

If you have other insurance

Call us at 1-866-408-6131 (TTY 711) if you or your children have other health benefits. This helps us work with your other insurance company to correctly pay claims. You can 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 health care. Let us know right away if you were hurt in an accident or if another company made payments for your health care. You'll need to let us know information about what happened. **Call the Subrogation department at 1-866-891-7397 (TTY 711).**



What to do if you get a bill from a provider

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 1-866-408-6131 (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.

Privacy Policies

We have the right to get information from those who give you care. We use this information so we can pay for and manage your health care. We keep this information private between you, your health care provider and Anthem, except as the law allows.

Refer to the Notice of Privacy Practices at the end of this member handbook to read about your right to privacy.

Your medical records

Federal and state laws allow you to see your medical records. Ask your PMP for your records first. If you have a problem getting your medical records from your doctor, call Member Services at 1-866-408-6131 (TTY 711).

Living wills (advance directive)

A living will or advance directive is a legal document that describes how you want to be treated if you cannot talk or make decisions for yourself. You can name someone else as the person who will decide about your health care if you're unable.

You also may want to list the types of care you do or do not want to get. For example, some people do not want to be put on life-support machines if they go into a coma. Your PMP will make sure your living will is in your medical records.

You may change or revoke your living will at any time by telling your PMP or other health care provider. You may file a complaint with the state survey and certification agency if you believe your doctor is not meeting the terms of your living will. Ask your family, PMP or someone you trust to help you. The forms you need are at office supply stores or a lawyer's office.

Quality Improvement

You deserve high quality medical and behavioral health care. Anthem's Quality Improvement program reviews the services you get from Anthem doctors, hospitals and other health care services. This ensures you receive care that is of good quality, helpful and right for you.

Your health is important to us, and we believe quality work yields quality results. We make information about our quality improvement program available every year on our website and in writing to members upon request and we work hard to make sure you have access to great care. We do this by:

- Having programs and services to help improve your quality of health care.
- Providing learning tools on pregnancy and newborn care for all pregnant members and new moms.
- Finding programs in your community that help you get services, if you need them.
- Hosting learning events to answer your questions and concerns and help you make the most of your health care.
- Following state and federal guidelines.
- Looking at our quality results to find new ways for better care.

Want to know more about our Quality Management program? Would you like to know how it works and how we're doing? Call Anthem at 1-866-408-6131 (TTY 711). Ask us to mail you Quality Management program information. We can also tell you more about the ways Anthem makes sure you get quality health care services.

You can review the quality and cost of care your hospital provides, as well. This can help you make the best decisions about your care. Visit these sites online to help you find out more:

- The Leapfrog Group — leapfroggroup.org
- Hospital Compare — www.hospitalcompare.hhs.gov
- Hospital Inpatient Quality Reporting Program <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html>
- Physician Quality Information — Indiana Health Information Exchange www.ihie.org

Your opinion is important to us. You'll receive a member satisfaction survey each year. If we helped you, please tell us in the survey. Your answers are anonymous. This information is used to improve our services and your care.

You can also be part of our Community Member Advisory Committee (CMAC). As part of this group, you can tell us your views and ideas to help us understand what our members need. It'll also help us to find out how we can improve the quality and cost of health care.

Reporting fraud and abuse

If you know someone who is misusing (through fraud, waste, abuse and/or overpayment) any Anthem program, you can report him or her.

To report doctors, clinics, hospitals, nursing homes or Anthem members, write or call us at:

Anthem Medicaid Special Investigations Unit

4425 Corporation Lane

Virginia Beach, VA 23462

1-877-725-2702

(TTY 1-866-494-8279)

Suspicious of fraud, waste and abuse can be emailed directly to the Anthem Medicaid Special Investigations Unit at corpinvest@anthem.com.

If we can no longer serve you

We can't keep you as a member of the health plan if you:

- Lose your eligibility.
- Are disenrolled from (no longer a member of) the HHW program.
- Move out of Indiana.
- Were signed up in error.
- Become eligible for Medicare.



You can leave HHW at any time. If you want to continue with your health benefits, but disenroll from Anthem, there are certain rules. See section called *Choosing a new health plan in Part 5*.



Part 6 – How to resolve a problem with Anthem

We care about the quality of care you get from us and your doctors. If you have a concern, call Member Services at 1-866-408-6131 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Here are some things we can help you with:

- Finding a doctor
- Finding care and treatment
- Issues about how we run the health plan
- Any aspect of your care

You will not be treated differently because you call us with a problem or complaint.

If you have a question

If you're not happy with the care you get from one of the doctors in your plan, please let us know.

There are two ways you, or someone you choose to act for you, can let us know your problem:

- **Call us** at 1-866-408-6131 (TTY 711).

- **Send us a letter** at:

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

Our Member Services staff will try to take care of your problem right away. They may have to send the information to the right staff person for a final answer. You may choose not to be named when you tell us, or send us information about, your problem.

Grievances

A grievance can be filed with us over the phone or in writing. You need to file your grievance within 60 calendar days from the date the problem took place.

If you have questions or concerns about your care, try to talk to your doctor first. Then if you still have questions or concerns, call us.

If you need help filing your grievance, one of our associates can help you. If you do not speak English, we can get an interpreter for you.

What if my problem has to do with a denial of my benefits?

You need to file an appeal instead of a grievance. Learn how to *Make an appeal*. The information is located in this section.

You have three ways to file a grievance with us

1. **Call Member Services** at 1-866-408-6131 (TTY 711).
2. **Complete a grievance form** found on www.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
- Why you're not happy



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

Grievance Coordinator

P.O. Box 62429

Virginia Beach, VA 23466

If we can't make a decision about your grievance within 30 calendar days, we can ask the state agency to give us extra time (up to 14 calendar days). If we do this, we'll send a letter to tell you why we need more time.

Expedited (rush) grievance

Members must request an expedited grievance by fax only. Please fax to **1-855-516-1083**.

If you think waiting 30 calendar days may harm your health, we may be able to give you an answer within 48 hours. This is called an expedited (faster) grievance. In your request, tell us why you think waiting 30 calendar days would harm your health. We'll make a decision and try to call you within 48 hours from the time we get your grievance. We'll also send you a letter within five business days after making our decision.

You also need to show facts proving your claim. This needs to be done within a certain time period. 30 calendar days won't harm your health, we'll send you a letter within two business days to let you know we'll complete your grievance as quickly as we can but within 30 calendar days. We'll also try to call you to tell you our decision.

Appeals

If you want to file an appeal about how we solved your problem, an appeal can be requested within 60 calendar days from the day of our decision on the grievance resolution letter.

Send your appeal to:

Appeals Department

P.O. Box 62429

Virginia Beach, VA 23466

We'll send you an acknowledgement letter within three business days after we get your appeal. The letter will tell you we got your appeal request.

You can also ask for an appeal by calling Member Services at 1-866-408-6131 (TTY 711). You must ask for an appeal in writing after you ask for one over the phone, unless you ask for a rush appeal.

We'll make a decision about your appeal within 30 calendar days after we get it. If we cannot decide within 30 calendar days, we can ask the state agency to give us more time (up to 14 calendar days). If we do this, we'll send you a letter to tell you why we need more time.

Once your appeal is resolved, we'll send you a letter to tell you about the decision explaining:

- How to file an external independent review request.
- Ways to get a faster review.
- Your right to keep your benefits during the review.
- That you may have to pay for care you get while you wait for the decision.

Expedited (rush) appeal

Members must request an expedited appeal by fax only. Please fax to **1-855-516-1083**.

You may ask us to rush your appeal if your health needs it. We'll let you know we got your appeal within 24 hours from the time we received it. We send you a letter with our decision within 48 hours. If we say no to your request for a rush appeal, we'll call and send you a letter with the reason for the delay within two calendar days.

You may keep your benefits while you're waiting for your appeal if you asked for the appeal within the right time frame. You may have to pay for the care you get while you wait for an answer about the appeal if the final decision is not what you wanted.

External independent review

We have a special process called an external independent review (EIR). This process provides a neutral review of benefit decisions made by Anthem.

The EIR is used to resolve grievance appeals if we said no to paying for a service:

- You or your doctor asked for.
- That has to do with your medical needs.
- You asked for that has not been proven to work.

A written request must be filed for this process. This must be filed within 60 calendar days from the date we told you that your appeal had been denied. Within three business days after we get your request, we'll send you a letter to say we got it.

EIRs are resolved within 15 business days from the date of request. We'll send you a letter with the answer within 72 hours from when we decided. The letter will explain:

- Your right to ask for a Medicaid hearing.
- How to ask for a hearing.
- Your right to keep your benefits until the hearing is over.
- That you may have to pay the costs for services that you're waiting for if the decision is not what you asked for at the start.

Expedited (rush) external independent review

You may ask us to rush your external independent review (EIR) if your health needs it. Members must request an expedited external independent review by fax only. Please fax to **1-855-516-1083**. We'll take care of your request as fast as we can, but no more than 72 hours from the time we get your appeal. We'll send you a letter within 24 hours after we make a decision.

Medicaid hearing and appeal process

If you have a problem with what we decide after completing our appeal process, you can ask for a Medicaid hearing and appeal review. You may ask for this review if we:

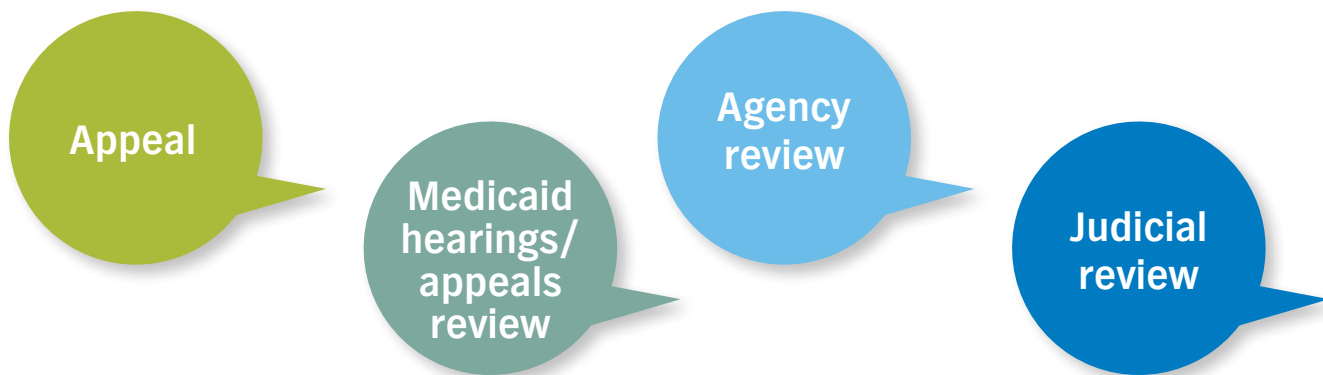
- Said no to paying for a service you wanted.
- Said OK to a service, but then we put limits on it.
- Ended payment for a service that we said OK to before.
- Did not give you access to a service fast enough.
- Did not confirm you were medically frail.

To ask for a review, you must send a letter to the state Medicaid agency within 60 calendar days of getting our decision about your appeal. Send your request to:

FSSA Hearings and Appeals

RM E034 — IGC-S, MS04, 402 W. Washington St., Indianapolis, IN 46204

Steps to take if you're unhappy:



A judge will hear your case and send you a letter with the decision within 90 business days of the date that you first asked for a hearing.

If you have a problem with the judge's decision, you can ask for an agency review. You must file for this review within 10 business days after you get your notice of the judge's decision.

You'll get a written notice of action from the agency review. If the hearing decision was reversed or changed, a letter will give the reasons.

If you're not happy with what the agency decides, you may file for a judicial review.



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.



HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
 - Lock our offices and files
 - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
 - Use passwords so only the right people can get in
 - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
 - Make rules for keeping information safe (called policies and procedures)
 - Teach people who work for us to follow the rules



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

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
 - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
 - To share information with the doctors, clinics and others who bill us for your care
 - When we say we'll pay for health care or services before you get them
 - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please visit www.anthem.com/inmedicaid for more information.
- **For health care business reasons**
 - To help with audits, fraud and abuse prevention programs, planning, and everyday work
 - To find ways to make our programs better
- **For public health reasons**
 - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
 - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
 - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-866-408-6131 (TTY 711)**.



What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019 | TDD: 1-800-537-7697 | Fax: 1-312-886-1807



We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at www.anthem.com/inmedicaid.

Race, ethnicity and language

We receive race, ethnicity and language information about you from the state Medicaid agency and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Develop and send health education information
- Let doctors know about your language needs
- Provide translator services

We do **not** use this information to:

- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

Your personal information

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
 - Health
 - Habits
 - Hobbies
- We may get PI about you from other people or groups like:
 - Doctors
 - Hospitals
 - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

www.anthem.com/inmedicaid

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc., independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Do you need help with your health care, 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 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

¿Necesita ayuda para con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Spanish

هل تحتاج إلى مساعدة فيما يتعلق برعايتك الصحية أو في التحدث معنا أو قراءة ما نرسله لك؟ نوفر المواد الخاصة بنا بلغات وتنسيقات أخرى مجانًا. اتصل بنا على الرقم المجاني 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan)؛ 1-844-284-1797 (Hoosier Care Connect)؛ الهاتف النصي 711 TTY.

Arabic

သင့်ကျန်းမာရေး စောင့်ရှောက်မှု၊ ကျွန်ုပ်တို့နှင့် ပြောဆိုမှု သို့မဟုတ် ကျွန်ုပ်တို့ သင့်ထံ ပေးပို့သည်ကို ဖတ်ရှုမှုအတွက် အကူအညီ လိုအပ်ပါသလား။ ကျွန်ုပ်တို့၏ စာရွက်စာတမ်းများ၊ အခြားဘာသာစကားများနှင့် ပုံစံများဖြင့် အခမဲ့ ရရှိနိုင်ပါသည်။ ဖုန်းခေါ်ခ အခမဲ့ဖြစ်သော 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan)၊ 1-844-284-1797 (Hoosier Care Connect)၊ TTY 711 သို့ ဖုန်းခေါ်ဆိုပါ။

Burmese

您在醫療保健方面、與我們交流或閱讀我們寄送的材料時是否需要幫助？我們免費為您提供用其他語言和格式製作的資料。致電我們的免費電話 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan)； 1-844-284-1797 (Hoosier Care Connect)；聽力障礙電傳 TTY 711。

Chinese

Hebt u hulp nodig bij uw gezondheidszorg, wil u met ons praten of lezen wat we naar u sturen? We bieden onze literatuur gratis aan u aan in andere talen en formaten. Bel ons gratis op 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Dutch

Avez-vous besoin d'aide pour vos soins de santé, pour parler avec nous ou pour lire ce que nous vous envoyons? Nous vous offrons notre matériel dans d'autres langues et formats, sans frais pour vous. Appelez-nous sans frais à 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

French

Brauchen Sie etwas Hilfestellung mit Ihrer Gesundheitsfürsorge, wenn Sie mit uns reden oder lesen, was wir Ihnen senden? Wir stellen unsere Materialien kostenfrei in anderen Sprachen und Formaten bereit. Rufen Sie uns gebührenfrei unter den folgenden Rufnummern an: 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

German

क्या आपको अपनी स्वास्थ्य देखभाल, हमारे साथ बात करने या हम जो आपको भेजते हैं उसे पढ़ने में सहायता की जरूरत है? हम अन्य भाषाओं एवं प्रारूपों में आपके लिए बिल्कुल मुफ्त अपनी सामग्रियों को प्रदान करते हैं। हमें टोल फ्री नंबर 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711 पर फोन करें.

Hindi

お客様のヘルスケアについて、お問い合わせの際やお手元に届く資料に関し、サポートが必要ですか？資料は他言語にて、また読みやすい文字の書式を無料にて提供しております。詳しくはフリーダイヤル、1-866-408-6131 (Hoosier Healthwise、Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711までお問い合わせください。

Japanese

건강 관리에 도움이 필요하십니까? 아니면 저희와 연락하시거나, 보내드린 자료를 읽는 데 도움이 필요하십니까? 자료를 다른 언어 및 형식으로 무료로 제공해드립니다. 저희에게 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711 번으로 연락해 주십시오.

Korean

Brauchscht du Hilfe mit dei Health Care, schwetze mit uns odder lese was mir dir schicke? Mir kenne unsere Materials in annere Schprooche un Formats mitaus Koscht gewwe. Ruf uns mitaus Koscht uff: 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Pennsylvania
Dutch

تہانوں اپنی نگہداشتِ صحت، ساڈے نال گل بات کرن یا جو اسی بھیجنے آں
اُونہوں پڑھن وچ مدد دی لوڑ اے؟ اسی تہانوں اپنے امواد پور زبانان تے فارمیٹس
وچ مُفت فراہم کردے آں۔ سانوں اپناں ٹال فری نمبراں تے مُفت کال کرو
1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan);
1-844-284-1797 (Hoosier Care Connect); TTY 711.

Punjabi

Вы нуждаетесь в помощи при получении медицинского обслуживания, во время общения с нами или с прочтением того, что мы вам посылаем? Мы предоставляем бесплатно наши материалы на других языках и в иных форматах. Позвоните нам бесплатно по телефону 1-866-408-6131 (программа Hoosier Healthwise, программа Healthy Indiana Plan); 1-844-284-1797 (программа Hoosier Care Connect); TTY 711.

Russian

Kailangan mo ba ng tulong sa iyong pangangalagang pangkalusugan, pakikipag-usap sa amin o pagbasa sa ipinapadala namin sa iyo? Ibinibigay ang aming mga materyal sa ibang mga wika at format nang wala kang babayaran. Tawagan kami nang libre sa 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Tagalog

Quý vị có cần giúp đỡ về dịch vụ chăm sóc sức khỏe của quý vị thông qua việc trao đổi với chúng tôi hoặc đọc những tài liệu mà chúng tôi gửi cho quý vị hay không? Chúng tôi cung cấp cho quý vị các tài liệu bằng các ngôn ngữ và định dạng khác miễn phí. Hãy gọi chúng tôi theo số điện thoại miễn cước 1-866-408-6131 (Hoosier Healthwise, Healthy Indiana Plan); 1-844-284-1797 (Hoosier Care Connect); TTY 711.

Vietnamese

To get this handbook in other formats, such as Braille, large print or audio CD, call Member Services at **1-866-408-6131 (TTY 711)** Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

You can learn more on our website at www.anthem.com/inmedicaid.



Anthem Blue Cross and Blue Shield 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

For people with disabilities or who speak a language other than English, 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 1-866-408-6131 (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, email, fax or phone:

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

Phone: 1-866-408-6131 (TTY 711)

Email: grievances@anthem.com

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:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

By mail:

U.S. Department of Health and Human Services
200 Independence Ave.
201 SW Room 509F, HHH Building
Washington, DC 20201

By phone:

1-800-368-1019 (TTY/TDD 1-800-537-7697)

For a complaint form, visit

www.hhs.gov/ocr/office/file/index.html.

Notes

