WE GET YOU *COVERED.*

mhs™

Member Handbook

Important information for you and your family.

Hoosier Healthwise

mhsindiana.com • 1-877-647-4848 • TTY/TDD: 1-800-743-3333

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The information in this book is available in other languages or formats, including Spanish, large print, Braille or audio CD. Please contact MHS Member Services by phone at 1-877-647-4848 or online at mhsindiana.com if you need this information in another language or format.

Welcome to MHS!

Thank you for making MHS your choice for better healthcare through your enrollment with Hoosier Healthwise. Here are the next steps you should take as a new member.

Complete Your Health Needs Screening Complete the survey online, over the phone at 1-888-252-3410 or at a Walmart pharmacy kiosk. ***Complete it within 30 days of becoming a member to get a $30 My Health Pays® reward.***

Sign Up for your Secure Member Portal Account Your portal account gives you access to your secure information, such as claims, your doctor's office's information, My Health Pays® balances and more.

Choose Your Doctor Use the Find a Provider search at mhsindiana.com. Then, sign in to your portal account or call us at 1-877-647-4848 to choose your doctor. ***You can earn a $15 My Health Pays® reward for using your portal account to choose a doctor within the first 30 days of becoming a member.***

Visit Your Doctor After you choose your doctor, set up an appointment for a checkup right away. This is your new medical home.

Read Your Handbook and Quick Reference Guide Your Handbook and Quick Reference Guide tell you about your benefits and the services and programs you can use as a member.

If You are Pregnant, Submit a Notification of Pregnancy form to MHS within your first trimester ($50) or within your second trimester ($25). ***Submit using the Member Portal or by calling 1-877-647-4848.***

MHS Benefits U! Text MHSTEXT to 36698 to get messages and reminders throughout your membership with MHS. (Standard messaging rates apply. Text STOPMHS to quit at any time.)

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WELCOME TO MHS

This member handbook gives an overview of your healthcare benefits. MHS wants to make it easy for you to make the most of your benefits and services. MHS can help you 24 hours a day, seven days a week.

How to Contact Us

Member Services	1-877-647-4848 Monday – Friday, 8 a.m. – 8 p.m. MHS is closed on the following days: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day
TTY/TDD Line	1-800-743-3333 (for members with speech or hearing disabilities)
24 Hour Nurse Advice Line	1-877-647-4848
Emergency	911
Website	mhsindiana.com
By Mail	MHS Member Services 429 N Pennsylvania St., Suite 109, Indianapolis, IN 46204

Stay Connected with MHS Online

Blog: mhsindiana.com

Managed Health Services-MHS

Managed Health Services

Emails from MHS

MHS will send you emails about your specific benefits, events in your city or town, and tips for healthy lifestyles. Make sure your email address is up-to-date with the State to get this important information.

MHS Member Services is here to help!

We can answer your questions about your health insurance, including benefits, doctors and MHS services. Here are some reasons you could contact Member Services:

- If you need to choose or change your doctor
- To complete your Health Needs Screening
- To schedule transportation
- If you get an invoice or bill from your doctor or healthcare provider
- To get language assistance
- If you have questions about decisions made regarding your care

MHS offers a 24 hour live voice phone service in English, Spanish and Burmese. You can leave a message, and MHS will call you back within one business day. Please contact MHS Member Services if you need help understanding any MHS written materials, such as brochures, flyers, letters and this handbook. We can send you materials in a different language or format, such as Spanish, large print, Braille or audio CD. You may also contact MHS Member Services to suggest changes to any of the policies, services and processes MHS provides to you as a member.

As a valued MHS member, you will hear from us regularly by phone, mail and email. Please read and respond to all the information we send, as it is key for your health as well as keeping your coverage.

If you don't hear from us, we may not have your correct phone number and address. Please tell us when you move or change your phone number.

Keep in Touch

Always let MHS and your state caseworker know if you move or get a new phone number or email address. If you move to another county or if you move more than 30 miles from your doctor's office, you may not be able to keep your doctor. Please call and talk to MHS Member Services if you move.

The Indiana DFR needs to know of changes to your current information. Call 1-800-403-0864 or go to FSSABenefits.IN.gov, Create an account or click "Report a Change".

When you report the change, you may be able to request a recalculation of your contribution or premium payments for HHW Package C (CHIP). Learn more about this on page 41.

MHS 24 Hour Free Nurse Advice Line

Everyone has questions about their health. If you have a question, you can reach the MHS 24 hour nurse advice line at 1-877-647-4848. The nurse advice line is a free, medical advice phone line staffed by bilingual licensed nurses. It is open 24 hours a day, every day of the year. Here are some questions you might ask:

- Questions about pregnancy
- What to do if your baby is sick
- How to deal with asthma
- How much medicine to use/give
- When to go to the emergency room

MHS can provide an in-person interpreter for all languages, including for those who use sign language.

Check with your doctor first. If the doctor does not have someone on staff to help out, then MHS will provide an interpreter for you. Please call us at least seven days before your doctor visit so we can make these plans for you.

Language Assistance

MHS provides bilingual staff or an interpreter to help members who speak languages other than English. We can help schedule appointments and answer questions over the phone. This service is free to use. Call MHS Member Services at 1-877-647-4848 and ask for language assistance.

Hearing impaired members can call the Indiana Relay Service at 1-800-743-3333 for TDD/TTY service. This number can be used anywhere in Indiana. Ask the operator to connect you to MHS at 1-877-647-4848, or to any other number. Tell your doctor if you need a sign language interpreter for your medical visits.

MHS Website: mhsindiana.com

MHS' website helps you get answers when it's convenient for you. If you don't have a printer, you can ask MHS to mail you any forms, web pages or any other printable information on mhsindiana.com, or the MHS Facebook page. These are some important pages on our website:

- **mhsindiana.com/HHWscreening**
  When you take your health needs screening within 30 days of joining MHS, you get a $30 My Health Pays® reward. Or take it within 90 days of joining MHS, and get a $10 My Health Pays® reward! Learn more about My Health Pays® on page 38.

- **For Members > Hoosier Healthwise > Benefits & Services**
  Find member updates and member guides, such as a copy of this handbook, brochures and how-to guides. You can also find copies of member forms, member newsletters and information about special MHS programs and services.

- **mhsindiana.com/find-a-provider**
  Find MHS in-plan doctors, specialists, hospitals and other facilities using this quick and easy online search.

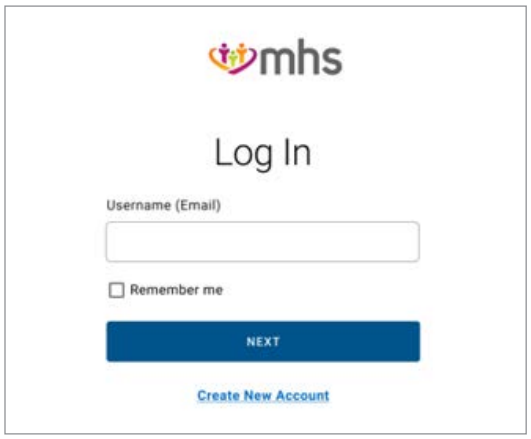
- **For Members > Hoosier Healthwise > Health & Wellness**
  Our free health library will help you find answers to your health questions. This resource has more than 4,000 health information sheets on a variety of health topics to help you care for yourself and your family.

- **mhsindiana.com/contact-us**
  Send MHS Member Services a message.

Sign Up for an MHS Secure Member Portal Account

Create an account and access tools that help you manage your healthcare faster and easier - all without having to pick up a phone:

- View your summary of benefits, including pharmacy benefits
- Find Explanation of Benefits (EOB) statements
- Find/change your doctor
- See doctor quality reports
- View and track your claims. You can see the amount approved, amount paid and date paid.
- Communicate with MHS Member Services
- Request, order or print an ID card
- Learn about referrals for care and if an authorization is required



If you are unsure if you should seek medical attention from an emergency room for a non-life threatening event, call your doctor's office first. If you can't reach your doctor, you can call the MHS 24 hour nurse advice line.

This tool will have the most up to date information, such as name, address, telephone numbers, whether they are accepting new patients, professional qualifications, languages spoken, gender, specialty and board certification status. For more information about a provider's medical school and residency, call MHS Member Services.

Your Coverage Year >>

Health Needs Screening

The Health Needs Screening (HNS) is a questionnaire that asks you about your health history and if you have any healthcare conditions. We want to know about your health right away so we can help match your needs with the right healthcare team. That's why we offer a way to earn reward dollars with the My Health Pays® program. MHS will give you a $30 My Health Pays® reward if you complete the HNS within 30 days of becoming a member. Or you can get a $10 My Health Pays® reward for completing it within 90 days of becoming a member.

Set up a First Appointment and Get to Know Your Doctor

After you choose your doctor, please call the doctor's office within 60 days to make an appointment for your first checkup or preventive care visit. MHS cares about you having a successful medical home. This means you need to develop a relationship with a doctor you trust and go to for all your medical care. This doctor is also called your Primary Medical Provider (PMP).

We will call you before 90 days are up, but you don't have to wait. Go to mhsindiana.com/HHWscreening, or call MHS Care Engagement and ask to take the survey.

Choose Your Doctor Right Away

MHS cares about you having a successful medical home. That begins with choosing MHS doctors for you and your family. As an MHS member, you get to choose the doctor you want. He or she will help manage your healthcare and help you get the services your family needs.

It's important you choose the doctor you want within 30 days of becoming an MHS member. If you don't, MHS will choose a doctor for you.

How to Choose your MHS Doctor:
First, find a list of doctors in your area:
- Go online at mhsindiana.com/find-a-provider, or
- Call MHS Member Services at 1-877-647-4848 and ask for a list.

Next, pick your doctor from the list. You can choose from the following types of MHS doctors:
- Family Practice
- General Practice
- Internal Medicine
- OB/GYN
- Pediatrician

Last, tell us!
- Choose your doctor through your Secure Member Portal Account at mhsindiana.com/login.
- Call Member Services at 1-877-647-4848.

Afterward, MHS will send you a letter confirming the doctor(s) you chose.

If You are Pregnant, Complete Your Notification of Pregnancy (NOP)

This form is available through your online account or by calling us. Completing this form can help you start earning additional My Health Pays® rewards.

WHAT TO DO NOW THAT YOU'RE ENROLLED

6 Months → **1 Year**

Get Your Preventive Care

The best way to stay healthy is to get your regular preventive care. Preventive care visits are FREE for all MHS members. Adults and children alike need preventive care and immunizations. Go to pages 16-19 for a schedule of yearly exams, screenings, and immunizations.

Keep Your Benefits

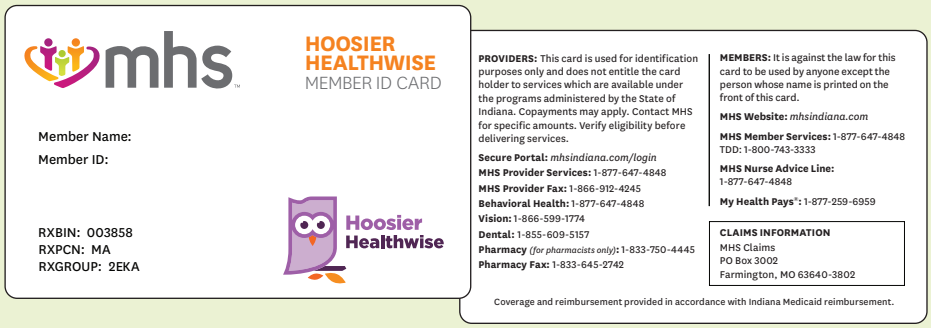
As your partner in health, we want you to continue receiving benefits if you need them. One calendar year after you begin your benefits through Hoosier Healthwise, you will need to renew your benefits through redetermination. Do you know the date of your next benefits renewal? Login to the FSSA Benefits Portal fssabenefits.in.gov or call DFR at 1-800-403-0864 for help.

MHS will send you an email and call you to help remind you when it's time to renew your benefits. Make sure that MHS has your correct phone number and email to receive these and other reminders.

As a Hoosier Healthwise member, you can get free transportation services to redetermination appointments. Learn more about your transportation benefits on page 37.

Always Show Your MHS Member ID Insurance Card

You must show your Hoosier Healthwise ID card each time you get medical care or go to the pharmacy. If you do not show your identification card, you may have to pay for your care: Medicaid eligibility can be verified if you can provide one of the following for the individual receiving services: MID, SSN/DOB, first and last name. If you receive a bill for covered services or are told to file a claim, please contact MHS Member Services right away at 1-877-647-4848.



Secondary Insurance

You must also show your identification cards for any other health insurance you have each time you get care. Please let MHS know if you have other health insurance. If you cancel or lose your other health insurance, please remember to update your information.

Your MHS doctor is your medical home. It is best to always speak with your doctor before you get healthcare services from another provider.

Covered Services

A covered service is a service that is paid for under your health benefits through Hoosier Healthwise or the Children's Health Insurance Plan HHW Package C (CHIP). Some services may not be covered under your benefit package. If a service is not covered, your doctor must tell you if you have to pay for the service. Some benefit packages have premiums and copays you must pay.

MHS Hoosier Healthwise Program Package A (Standard Plan)

Hoosier Healthwise provides coverage for all essential health benefits to pregnant women, children and former foster children through age 25.

BENEFIT	COVERAGE
During and after pregnancy care - Call MHS right away if you become pregnant	Covered
Well-child checkups (Early Periodic Screening, Diagnosis & Treatments)	Covered
Orthotics – leg braces, orthopedic shoes, prosthetics	Covered
Cosmetic procedures	No
Diabetes strips, blood sugar monitoring	Covered
Tests to find if you have a health condition (diagnostics)	Covered
Developmental delay evaluation and treatment	Covered
Foot care	Covered
Treatment for learning disability, problem solving or memory issues	No
Hearing aids (every five years)	Covered
Home healthcare	Covered
Hospital stays	Covered
Labs/X-rays	Covered
Medical supplies/equipment	Covered
New or experimental services or alternative therapies	No
Free ride services to doctor visits, pharmacy, emergency care and Medicaid redetermination appointments	Covered
Surgeries (outpatient)	Covered
Continued care after hospital stays (post stabilization)	Covered
Prescriptions	Covered
Doctor visits (services from your PMP/family doctor)	Covered
Referrals to specialists	Covered
Authorized therapies – physical, speech, occupational, respiratory	Covered
Hospice	No

Contact MHS Member Services at 1-877-647-4848 for more information about services for learning disabilities and mental rehabilitation services, which could be covered under other programs.

HOOSIER HEALTHWISE COVERED SERVICES

Hoosier Healthwise Self-Referral Services

You can receive some services without seeing your doctor to get a referral, as long as you visit an Indiana Medicaid provider. You can find a list of Indiana Medicaid providers at indianamedicaid.com.

The following Self-Referred Services do not require a referral from your PMP or approval from MHS.
Members may self-refer to any qualified provider enrolled in Medicaid:
Chiropractor
Routine vision (optical) care
Psychiatric services
Podiatry (foot) care
Family planning
Emergency services
Urgent care
Immunizations
Diabetes self-management
These services are self-referral if given by an in-network provider:
Routine dental care
Behavioral health (mental health, substance abuse, chemical dependency)

It is just as important to care for your mental well-being as it is to care for your physical health. You can find a behavioral health doctor online on our find a provider search. MHS also has case management programs for certain conditions.
Learn more on page 33.

Covered Services

A covered service is a service that is paid for under your health benefits through Hoosier Healthwise or the Children's Health Insurance Plan HHW Package C (CHIP). Some services may not be covered under your benefit package. If a service is not covered, your doctor must tell you if you have to pay for the service. Some benefit packages have premiums and copays you must pay.

HHW Package C (CHIP) allows families to receive healthcare benefits through the Hoosier Healthwise program. HHW Package C (CHIP) coverage is for qualifying children under age 19 who meet the program criteria.

HHW Package C (CHIP) Premiums

There is a small monthly premium payment for all HHW Package C (CHIP) members. You will pay your monthly premium to the State, not to MHS. The amount you are required to pay is based on your family income and number of children on the HHW Package C (CHIP) program in your family. Visit indianamedicaid.com for specific amounts.

HHW Package C (CHIP) Late Payments and Disenrollment

Monthly premiums are due by the due date listed on your monthly invoice from the State. After that due date, you have 60 days to make your payment before you lose HHW Package C (CHIP) coverage.

If your family has been disenrolled due to non-payment of premiums, you can reapply. But you will not be eligible until all past due premiums and the premium for the current month are paid to the State. A payment of less than the full amount due will not be accepted and will be considered nonpayment.

You will not be charged for the time between the date of disenrollment and the date that coverage resumes. However, any services received during that time period will not be retroactively covered.

HHW Package C (CHIP) Copayments

HHW Package C (CHIP) members have copayments for some services:

SERVICE	COPAYMENT
Prescription Drugs – Generic, Compound and Sole-Source	$3
Prescription Drugs – Brand Name	$10
Emergency Ambulance Transportation	$10

Any medication dispensed as an Emergency Supply will not have a copay.

HOOSIER HEALTHWISE PACKAGE C (CHIP) COVERED SERVICES

Your HHW Package C (CHIP) Health Benefits

Contact your MHS doctor to receive referral and hospital services. Or call MHS Member Services at 1-877-647-4848. They can help you find doctors or arrange any needed services.

BENEFIT	COVERAGE
During and after pregnancy care - Call MHS right away if you become pregnant	Covered
Well-child checkups (Early Periodic Screening, Diagnosis & Treatments)	Covered
Orthotics – leg braces, orthopedic shoes, prosthetics	Covered
Cosmetic procedures	No
Diabetes strips, blood sugar monitoring	Covered
Tests to find if you have a health condition (diagnostics)	Covered
Developmental delay evaluation and treatment	Covered
Foot care	Covered
Treatment for learning disability, problem solving or memory issues	No
Hearing aids (every five years)	Covered
Home healthcare	Covered
Hospital stays	Covered
Labs/X-rays	Covered
Medical supplies/equipment	Covered
New or experimental services or alternative therapies	No
Free ride services to doctor visits, pharmacy, emergency care and Medicaid redetermination appointments	Enhanced Benefit for CHIP members
Surgeries (outpatient)	Covered
Continued care after hospital stays (post stabilization)	Covered
Prescriptions (copay may be required)	Covered
Doctor visits (services from your PMP/family doctor)	Covered
Referrals to specialists	Covered
Authorized therapies – physical, speech, occupational, respiratory	Covered
Hospice	No

Your MHS doctor is your medical home. It is best to always speak with your doctor before you get healthcare services from another provider.

HOOSIER HEALTHWISE PACKAGE C (CHIP) COVERED SERVICES

It is just as important to care for your mental well-being as it is to care for your physical health. You can find a behavioral health doctor online on our find a provider search. MHS also has case management programs for certain conditions. *Learn more on page 33.*

HHW Package C (CHIP) Self-Referral Services

You can receive self-referral services without seeing your doctor to get a referral. For these services, you can visit any Indiana Medicaid provider, and HHW Package C (CHIP) will pay for covered services. You can find a list of Indiana Medicaid providers at IndianaMedicaid.com.

The following Self-Referred Services do not require a referral from your PMP or approval from MHS.
Members may self-refer to any qualified provider enrolled in Medicaid:
Chiropractor
Routine vision (optical) care
Psychiatric services
Podiatry (foot) care
Family planning
Emergency services
Urgent care
Immunizations
Diabetes self-management
These services are self-referral if given by an in-network provider:
Routine dental care
Behavioral health (mental health, substance abuse, chemical dependency)

Exams, Screenings and Immunizations For Children

There are a series of tests your child needs to receive every year from birth to age 21. These tests are called well-child checkups, HealthWatch visits or Early Periodic Screening, Diagnosis and Treatment (EPSDT) visits. Your child should be screened early so health problems can be found and treated. Treatment for any condition proved medically necessary is covered. MHS and your doctor will remind you when it's time for your next screening.

Every wellness visit is to include:

- Comprehensive unclothed physical examination
- Age-appropriate immunizations (see immunization schedule on next page)
- Assessment of nutritional status/measurements
- Age appropriate vision and hearing tests, and screenings for acuity
- Oral health risk assessments and dental referrals
- Laboratory tests as indicated
- Screening for blood lead toxicity beginning at 6 months, to include:
  - Blood lead test between the 9th and 15th month, or as close as reasonably possible to the child's appointment.
  - Another blood level test between the 21st and 27th month, or as reasonably possible to the child's appointment.
  - Children who have not been previously tested should be tested between the 28th and 72nd month
  - If the child is at high risk for lead exposure, the initial screening should be performed at the 6th month visit
  - A blood lead test result equal or greater to 3.5 ug/dl requires confirmatory testing and appropriate follow-up
- Developmental, behavioral, psychosocial and depression surveillance and screenings
  - Including tobacco, alcohol usage, and maternal depression screenings
- Health Education, additional diagnoses, treatment and referrals to specialists as needed, and anticipatory guidance for both the child and caregiver

The FSSA has elected to make Bright Futures the standard for infant, child and adolescent health supervision. See the Bright Futures website at *brightfutures.aap.org.* For a complete listing of the preventive health guides, please visit mhsindiana.com. More importantly, you should ask your doctor at each visit if your children are up to date on all preventive health requirements for children up to age 21.

Immunizations (Shots)

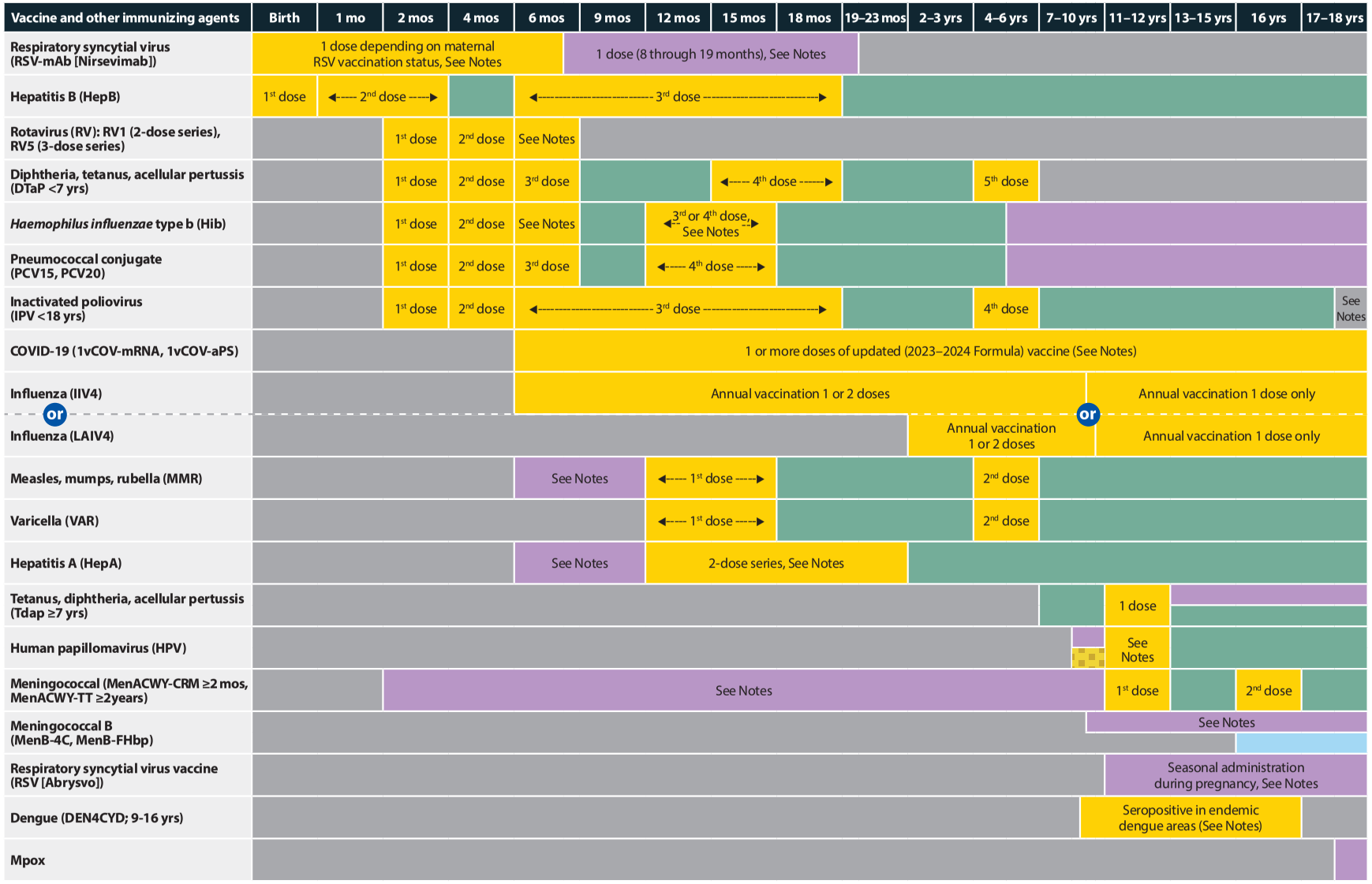
Your doctor will usually give immunizations (shots) during a well-child check-up. Each one of these shots helps protect your child, your family, and your community from dangerous disease and illness. If you think your child may be due for an immunization, please call to set up their next appointment right away. Review the chart on the next page to find out what immunizations are given at each age/check-up.

You can earn My Health Pays® rewards for each well-child checkup for children 0-15 months, for up to six visits. You can also earn My Health Pays® rewards for each yearly well-child checkup for children age 15 months to 20 years old. Learn more about the My Health Pays® Rewards program on page 38.

MHS may send you Healthy Reminders in the mail if your child needs an immunization or well-child check-up. If you get a reminder, make sure to set up your child's appointment with his or her doctor right away.

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).



Recommended Immunization Schedule for Persons aged birth to 18 years old *(referring to chart on previous page)*

https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

You can find this chart and more preventative care guides at mhsindiana.com.
Click on For Members > Hoosier Healthwise > Benefits & Services > Benefits Overview > Doctor Visits & Screenings.

For Adults *(referring to chart on next page)*

Every year, adults need to receive an annual check-up from their doctor. Depending on your age and gender, you may need certain screenings and even immunizations.

Women's Health Preventive Care *(referring to chart on next page)*

Women need certain health tests men don't need. These tests are simple screenings that can make a big difference. All women should talk to their doctor about getting preventive care screenings such as Pap tests, chlamydia tests and mammograms. Women's preventive health screenings and getting birth control (family planning) are self-referral services. That means you can see a doctor other than your MHS doctor. You do not have to get a referral from your doctor, but you must visit an Indiana Medicaid network provider.

SCREENINGS	AGE IN YEARS: 18	20	25	30	35	40	45	50	55	60	65	70	75+
Well-Person Exam Talk to your doctor about physical, mental and lifestyle issues to promote a healthy life.	Every year for both men and women												
Blood Pressure Know your numbers – Keep your blood pressure under control.	Every year for both men and women												
Body Mass Index (BMI) Stay at a healthy weight. Find out your BMI.	Every year for both men and women												
Abdominal Aortic Aneurysm Screening One-time screening by ultrasound for men with a history of smoking.											Men at higher risk		
Breast Cancer Screening Universal screening at age 50; age 40 talk with your doctor.								All Women					
						Women at higher risk							
Cervical Cancer Prevention Age 21-65: PAP test every 3 years. Age 30-65: Every 5 years if you have both a PAP test and an HIV test.		Women											
Chlamydia Screening *Sexually-active women ages 16-24 at least annually. Women age 25 and older at increased risk.	*Women		Women at higher risk										
Cholesterol Screening Men ages 25-35 & women over age 20 who are at increased risk for heart disease. All men aged 35 and older.					All Men								
		Men at higher risk											
		Women at higher risk											
Colorectal Cancer Screening Fecal Occult Blood Test (FOBT) Annually -OR- Sigmoidoscopy every 5 years, with high-sensitivity FOBT every 3 years -OR- Screening colonoscopy every 10 years							Both Men & Women						
Depression Screening Discuss life stress with your doctor. Getting help is the best thing you can do.	Both Men & Women												
Dental Care Take care of your teeth and gums. Get a routine dental visit at least once a year.	Both Men & Women												
Diabetes (Type 2) Screening You can do a lot to prevent or delay getting Type 2 diabetes.	Every year for both Men & Women												
Hepatitis C Screening	Men & Women at risk for infection and all adults born between 1945 and 1965												
HIV Screening	Both Men & Women												
											Those at high risk		
Osteoporosis Screening Keep your bones strong. People at increased risk need bone density testing.								Women at higher risk			All Women		

References: US Preventive Services Task Force • JNC Express: Prevention, Detection Evaluation and Treatment of High Blood Pressure • National Heart, Lung, and Blood Institute • www.cdc.gov/STD/chlamydia

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Behavioral (mental health) problems are very common. But sometimes people don't want to talk about these problems because they feel embarrassed or ashamed. This is known as stigma.

One thing we all can do is talk with people that have mental health problems. This is a way to allow a person to talk about what is happening to them. When you meet a person with mental illness who is able to work a job or be a good neighbor, stigma is reduced.

Behavioral healthcare is care for your mental health. A person struggling with their behavioral health may face stress, depression, anxiety, or need help with substance abuse.

MHS has behavioral health case managers who help members with special healthcare needs by working together with you and your behavioral health doctor to make a plan of care.

If you are having one of the following problems, please call MHS at 1-877-647-4848 and follow the prompts for behavioral health:

- You are worried about substance abuse or mental health issues
- You are sad or feel you need help
- You need names of therapists or doctors
- You need help to find resources in your community for mental health
- You don't understand your mental health benefits
- You need mental health services and you are not near your home
- A self-referred Behavioral Health service (mental health, substance abuse, chemical dependency) does not require a referral from your PMP or approval from MHS.

Crisis Text Line

If you are in crisis and need support, you can text MHS to 741741. It's free, confidential and available 24/7. If you don't want to use MHS, or if someone in your household is not eligible with MHS, you can use the National Suicide Prevention Lifeline. Call, text or chat with trained counselors using 988.

Covered Behavioral Health Services

- Diagnostic services
- Second opinions
- Crisis intervention
- Psychological testing
- Inpatient and outpatient
- Intensive outpatient programs
- Addiction counseling and treatment
- Partial hospitalization
- Residential Substance Use Disorder Treatment
- Opioid Treatment Program (OTP)

Long-term care, home and community-based waiver services, state psychiatric facility services and psychiatric residential treatment facility services are not covered by Hoosier Healthwise or HHW Package C (CHIP).

Behavioral Health Programs

- **Pregnancy and Post-Partum Care**: If you are pregnant or just had a baby, you will get a survey and information about depression. If your survey shows you may be experiencing signs of depression, MHS will contact you. It's important you get the help you need to have a positive pregnancy and a healthy baby.

- **Intensive Care Management Programs**: MHS has case management programs for several behavioral health conditions.

  – **Autism/Pervasive Developmental Disease Program (Autism Spectrum Disorders)**: MHS' program helps you get needed care and treatment to improve social, communication, behavioral, medical and other problems that may be present. We want to help you learn more about autism and how to work toward self-care management. We also work to help obtain other available services that can improve learning and other skills.

  – **Bipolar Disorder Management Program**: MHS' bipolar disorder program helps you understand your emotions. We want to get members the help they need to live a better, happier life. MHS partners with various providers who know how to treat people who experience symptoms of bipolar disorder.

  – **Hospital Admission Follow Up**: If you or your child has been in the hospital for a mental health or substance abuse reason, MHS can help. You or your child needs to be safe at home. MHS will help make sure you or your child makes their follow-up appointments and takes all needed medicines as directed by the hospital.

- **Medicaid Rehabilitation Option (MRO) and Other Services**: Coverage of MRO and psychiatric residential treatment facility services is managed directly by the state of Indiana. MHS will work with the State and your doctors to coordinate this care.

  – **Family Services Plan**: Members may also be eligible for an Individualized Family Services Plan under the First Steps program for very young children or an Individualized Education Plan for school-based services. These programs are also managed directly by the State, and MHS coordinates with them to ensure members are getting all the care they need.

- **Choose Health Program**: Designed to help individuals diagnosed with depression, ADHD or perinatal depression by giving them the tools to reach their health and wellness goals. When it comes to your health and well-being, it is important to understand mental health is part of overall health. As a part of the program, you will have access to another healthcare professional, your Choose Health Coach. We will work with you and your doctor to make sure you have everything you need to feel your best again. We will also talk with other members of the healthcare team, including mental health specialists, to help with any problems that may come up. Please contact us if you are interested in joining this program.

  – **Attention Deficit and Hyperactivity Disorder (ADHD) Program**: MHS' ADHD program helps you understand and manage the social, psychological and behavioral issues that often come with ADHD. We help parents and children learn to address problems and live happy, healthy lives with ADHD.

  – **Depression Program**: Members who experience long periods of sadness, feelings of hopelessness or unhappiness may have depression. MHS' depression program helps you find the cause(s) of your sad feelings, solve any immediate crises, improve your level of functioning and get needed medication and/or counseling.

Having a medical home for your dental care is important. Your dentist reviews your care year to year to find important preventive care needs, just like your medical doctor.

Dental Benefits

Benefits include:

- Oral Exams: One every six months per member
- Cleanings: One every six months per member, ages 12 months and up
- Fluoride treatments: Once every 6 months for members through age 20
- Bitewing x-ray series: One set every 12 months
- Full-mouth radiograph series or panoramic x-rays: One set every three years
- Periodontal services including scaling and root planing
- Sealants: One per tooth, per lifetime, for members 20 years of age and younger
- Minor restorative services, such as fillings
- Major restorative services, such as crowns
- Tooth extractions (based on medical necessity)
- Orthodontia for members through age 20 (based on medical necessity)
- Dentures, partials, and repairs (with limits)
- Dental surgery (with limits)
- Emergency dental services

Some dental services must be approved in advance by MHS, including dentures and dental surgery. Your dentist can help you get approval.

Find a Dentist

- Go online to mhsindiana.com/find-a-provider
- Call Member Services at 1-877-647-4848

Your Dental Visit

During your visit, your dental provider will make sure your teeth and gums are healthy. If problems are found, your dentist or dental hygienist will recommend self-care and treatment.

Your Health History

Since oral health is linked to general health, your visit will likely start with your health history. Tell your dental provider about any health problems you have or medicines you take. This includes any over-the-counter medicines, herbs, or supplements you take, as well as recreational drugs you use. You may also be asked about your daily tooth and gum care. Tell your dental provider if you grind your teeth or often breathe through your mouth. You should also bring up any oral health issues that concern you.

Your Dental Evaluation

Your dentist or dental hygienist may start by screening for oral cancer. This involves feeling your neck and throat and looking inside your mouth. Then your dental provider will:

- **Examine your teeth.** If you have any tooth decay, it will be marked on your dental record. Notes will be made about any restorations, like fillings or cracked teeth.
- **Examine your gums.** A probe is used to measure any pockets (areas where the gum has separated from the tooth) and gum recession. Your dentist or dental hygienist will also evaluate any bleeding that occurs. (Bleeding gums can be a sign of gum disease.)
- **Take X-rays and impressions** (pictures and molds of the teeth), if needed. These will be put in your record so your dentist or dental hygienist can refer to them at your next visit. This helps keep track of any changes to your mouth over time.

Cleaning and More

Depending on what your dental provider finds, the rest of your visit may include:

- A cleaning to help prevent gum disease. Your dental provider will clean below the gumline, where your toothbrush and floss can't reach.
- A cosmetic polishing to remove stains on the surfaces of your teeth (if needed).
- Further evaluation and treatment for any problems your dental provider finds. You may be referred to a specialist.
- Instruction for giving your teeth and gums the best care at home.

Vision Benefits

Vision benefits for Hoosier Healthwise and HHW Package C (CHIP) are provided as part of your MHS benefits.

Find an Eye Doctor

- Go online to visionbenefits.envolvehealth.com
- Click on "Provider Search" at the top of the page.
- Choose "MHS Health Services – Indiana (Medicaid)" as your "HealthPlan"
- Or call MHS Member Services at 1-877-647-4848.

Covered Routine Care

- Members ages 20 and younger:
  - One routine vision exam every year
  - New eyeglasses after your exam if your vision has changed significantly since your last pair, or as determined by your doctor.

- Members ages 21 and older:
  - One routine vision exam every two years
  - New eyeglasses after your exam if your vision has changed significantly since your last pair, or as determined by your doctor. If your vision has not changed, then you are covered for new eyeglasses once every two years.

Additional Coverage

- Replacement eyeglasses and/or frames for lost, damaged, or stolen frames, as determined by your doctor.
- Contact lenses are covered if you have a medical reason you cannot wear glasses, as determined by your doctor.
- Medically necessary eye tests and treatment for members with eye disease or other diseases that affect the eyes.
- Vision surgery and training therapies are covered if medically necessary, as determined by your doctor.

Enhanced Vision Benefits

Members may opt out of the standard eyewear benefit and receive $75 toward contact lenses and lens fitting.

Having a medical home for your vision care is important. Your eye doctor reviews your care year to year to find important preventive care needs, just like your medical doctor.

PHARMACY SERVICES

You must show your Hoosier Healthwise identification card each time you get medical care or go to the pharmacy. This ensures you are getting to use the benefits that are a part of your plan.

When you need either prescription or over-the-counter (OTC) drugs, your doctor will write you a prescription. Your doctor will either contact your pharmacy directly, or you can take the written prescription to your pharmacy.

Find a Pharmacy

All MHS members must use an in-network pharmacy, including mail-order pharmacies. Find a pharmacy online at mhsindiana.com/find-a-provider.

Covered Prescriptions/Preferred Drug List (PDL)

Prescription drugs are covered if the drug is approved by the U.S. Food and Drug Administration (FDA). This includes self-injectable drugs (such as insulin), and drugs to help you quit smoking. OTC drugs are only covered if listed in the OTC drug formulary.

Items that you need to care for diabetes are also a covered benefit. This includes items such as needles, syringes, blood glucose monitors, test strips, lancets and glucose urine testing strips. You can get these items at your pharmacy.

Your pharmacy benefit has a Preferred Drug List (PDL). The PDL shows the drugs that are covered. A team of doctors and pharmacists update this list four times a year. Updating this list makes sure the drugs are safe and useful for you and cost-effective for the Indiana Medicaid program.

Some OTC drugs are covered by Indiana Medicaid. Even listed OTC drugs require a doctor's prescription to be covered.

You can find a link to your PDL and OTC drug formulary on the MHS website at mhsindiana.com. Click on For Members > Hoosier Healthwise > Benefits & Services > Pharmacy.

Non-Covered Prescriptions

- Drugs that do not have FDA approval
- Experimental or investigational drugs
- Drugs to help you get pregnant
- Drugs used for weight loss
- Cosmetic or hair-growth drugs
- Drugs used to treat erectile problems
- Drugs not on the OTC drug formulary

Generic and Preferred Drugs

Your pharmacist will give you generic drugs when your doctor has approved them. Generic drugs are the same as brand-name drugs and make healthcare more affordable. Generic drugs must be used when available. If they are not available, brand-name drugs may be used. Or, if the brand-name drug is less costly, then it may be considered the "preferred drug."

Generic and preferred drugs must be used when available for your medical condition unless your doctor provides a medical reason you must use a different drug.

Prior Authorization for Drugs

Some drugs may need prior authorization before they are covered. To get authorization, your doctor will need to provide information about your health and then a decision will be made if the drug is covered. Your doctor must send a request for prior authorization if:

- A drug is listed as non-preferred on the PDL or if certain conditions need to be met before you get the drug
- You are getting more of the drug than is usually prescribed
- There are other drugs that should be tried first

In most cases, you may get up to a three-day (72 hour) supply of a drug that requires prior authorization while you are waiting for a decision. The decision will be made within one day (24 hours), not including Sundays or some holidays. Your provider will be notified of the decision. Your provider can find prior authorization forms on the MHS website at mhsindiana.com.

If you are unsure if you should seek medical attention from an emergency room for a non life threatening event, call your doctor's office first. If you can't reach your doctor, you can call the MHS 24 hour nurse advice line."

When and Where to Go for Care

It's important to visit the right doctor for the right kind of care. You might hear the words Primary Medical Provider (PMP), practitioner, physician and provider from MHS. All these titles mean a doctor or a facility where you get healthcare services.

Your Primary Medical Provider (PMP): You should visit your PMP for sick visits, regular checkups, immunizations (shots), prescriptions, referrals to specialists and hospitals, and pregnancy care.

Specialists: A specialist is a doctor who works in one healthcare area. For example, a doctor who only works with the heart (a cardiologist) is a specialist. In order to visit a specialist, you need to get a referral from your PMP, first.

Walk-In Clinic/Urgent Care Facility: Walk-in clinics provide high-quality care when quick medical attention is needed for non-life-threatening conditions.

Emergency Room (ER): Emergency care is there for you when you feel you have a life-threatening medical emergency. If you are not sure if you're having an emergency, please call your PMP. If you cannot reach your PMP's office, you can call MHS' 24 hour nurse advice line. If either your doctor or the nurse advice line advises you to go to the ER, then you will not be charged a copay for your ER visit.

You Deserve a Medical Home – A Primary Medical Provider (PMP)

You deserve a successful medical home, where:

- You and your doctor can build a trusting relationship.
- You have a place you can always go to for sick visits and regular check-ups.
- You feel that your doctor and his or her staff care for you and are responsible for your healthcare.

Teens and young adults have special healthcare concerns and issues. It's important to have a doctor who can address those needs. If you are close to age 18 and see a pediatrician, talk to your doctor about moving to an adult primary medical provider.

Visit your PMP for sick visits, regular checkups, immunizations (shots), prescriptions, referrals to specialists and hospitals, and pregnancy care. Your PMP will work to know your medical history, take the time to listen to your concerns, explain things to you in a way you can understand, and work with you to keep you healthy.

Always call your doctor to cancel appointments. If you do not cancel your appointments, and if you miss more than three appointments, your doctor may have the right to ask MHS to move you to a different doctor.

Choose or Change Your MHS Doctor

Whether you are choosing your doctor for the first time or changing your doctor, the process is easy and fast. You can change your doctor at any time. New members need to choose their doctor within the first 30 days of becoming an MHS member. If you do not choose a doctor, you are assigned to a doctor on the 30th day of your membership.

First, find a list of doctors in your area:

- Go online at mhsindiana.com/find-a-provider
- Or call MHS Member Services at 1-877-647-4848 and ask for a list

Next, pick your PMP from the list:

- Family Practice
- General Practice
- Internal Medicine
- OB/GYN
- Pediatrician

And from the following types of PMPs:

- Medical Doctor (MD)
- Doctor of Osteopathic Medicine (DO)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Nurse Midwife
- Clinical Nurse Specialist (CNS)

Last, tell us! You can tell us one of two ways:

1) Choose your doctor through the Secure Member Portal at mhsindiana.com/login. New members can earn a reward by choosing their PMP this way.
2) Call MHS Member Services at 1-877-647-4848, and tell us who you want as your doctor.

Afterward, MHS will send you a letter confirming the doctor(s) you chose.

How Long it May Take to Schedule an Appointment

MHS wants you to get care when you need it. We work hard to build a network of providers that works for you, and our network keeps growing. But, sometimes you will still need to wait to see a provider. We use the State's standards for appointment wait times. Please call MHS Member Services if you have a question or concern about the appointment wait time at your doctor's office. Here is how long it should take to schedule an appointment with your doctor:

APPOINTMENT TYPE	APPOINTMENT SCHEDULED BY:
Urgent care or sick visits	Scheduled within one day (24 hours)
Non-urgent visits	Scheduled within three days (72 hours)
Adult preventive exams / annual well-care visits	Scheduled within three months
New pregnancy visit	Scheduled within one month
Child preventive exams / well-child check-ups	Scheduled within one month
Exams for children with special needs	Scheduled within one month

When you are in the doctor's office, you should only have to wait up to one hour for your scheduled appointment.

The MHS Provider Relations team works throughout the year to add doctors, facilities and hospitals to MHS' network. The more MHS has to offer in our network near you, the more options there are for YOU.

Get the Most from Your Doctor Visit

- Arrive on time
- Bring your insurance card and photo ID
- Turn off your cell phones and other electronic devices
- Write down a list of questions to ask the doctor
- Bring your medical and shot records and any medicine you are currently taking
- Describe symptoms and complaints
- Ask questions and take notes during each visit
- Discuss next steps for your care plan with the doctor
- Schedule follow-up visits and any yearly check-ups

Specialists

A specialist is a doctor who works in one healthcare area. For example, a doctor who only works with the heart (a cardiologist) is a specialist. Your doctor may refer you to see a specialist if needed. Normally, your doctor will refer you to another MHS network doctor unless your medical condition could be better treated by someone other than an MHS network doctor.

When you visit a specialist, please make sure the specialist has the correct contact information for your doctor. Your specialist will send a report to your doctor that details your care plan.

Self-Referral Services

MHS allows for some self-referral specialist visits. A self-referral means you do not have to get a referral from your doctor. For a list of self-referral services for Hoosier Healthwise, see page 11; for HHW Package C (CHIP), see page 13.

PMP or Specialist Office Changes

Sometimes you can no longer be assigned to a doctor or specialist because the doctor is moving locations, moving to a new health plan (no longer on the MHS plan), or because the doctor is no longer accepting patients of your age or gender. If this change happens with a doctor you are currently seeing, MHS will send you a letter to let you know. The letter will explain what options you have and if you can choose to stay with your doctor.

You may continue to see your doctor if they have left the network through the current period of active treatment, or for up to 90 calendar days, whichever is less, if undergoing active treatment for a chronic or acute condition. If you are pregnant and already in your second or third trimester you may continue with your doctor until 30 days after delivery.

Continuity of Care

We are here to help our members get continuing care and coordination of medically necessary health care when they join/leave MHS. If you want to know if continuity of care is for you, or you would like a copy of our transition of care policy, please call Member Services.

Walk-In & Urgent Care Clinics

(NON-EMERGENCY/AFTER-HOURS CARE)

If you are having a medical problem that is not life-threatening but you're not sure what to do, you should always call your doctor first. Even if the office is closed, listen to the message and follow the instructions for after-hours care. MHS requires all doctors have an after-hours phone line. If you cannot reach your doctor, you can call the free MHS 24 hour nurse advice line.

If you are having a medical problem that is not life-threatening and need to see a doctor right away, please consider using a walk-in clinic or urgent care clinic before going to the emergency room.

Walk-In Clinics

Walk-in clinics provide high-quality care when quick medical attention is needed for non-life-threatening conditions such as:

- Sprains, strains, fractures and cuts
- Flu and cold symptoms
- Work-related illness or injuries
- Minor burns
- Stings or bites
- Ear ache, sore throat and fever

Urgent Care Clinics

Many clinics are open later in the evening and have extended weekend hours. Urgent care clinics help patients get care without waiting in the emergency room of their local hospital. These clinics may use physician assistants and nurse practitioners to treat you. Physician assistants and nurse practitioners are trained and supervised in providing medical care. They perform many of the routine services physicians usually provide. They can take medical histories, perform physicals and exams, order medications, lab tests and X-rays, and teach patients how to stay healthy.

Visit mhsindiana.com/find-a-provider to find a clinic near you.

You must show your Hoosier Healthwise identification card each time you get medical care or go to the pharmacy. If you do not show your identification card, you may have to pay for your care. If you receive a bill for covered services or are told to file a claim, please contact MHS Member Services right away at 1-877-647-4848.

Emergency Room: Know When to Go

Emergency care is there for you when you feel you have a life-threatening medical emergency. A life-threatening medical emergency is an illness or injury of such severity, including severe pain, that the lack of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- Place the individual's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of bodily organ or part of the individual.

If you are unsure if you should seek medical attention from an emergency room for a non-life threatening event, call your doctor's office first. If you can't reach your doctor, you can call the MHS 24 hour nurse advice line.

When to Go to the Emergency Room

- Broken bones
- Gun or knife wounds
- Bleeding that will not stop
- You are pregnant, and either in labor or bleeding
- Severe chest pain or heart attack
- Drug overdose
- Poisoning
- Bad burns
- Shock (you may sweat, feel thirsty or dizzy, or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move or speak

This is not a complete list of when you should get emergency care. If you have a health condition that occurs often (a chronic condition), talk to your doctor about what a life-threatening medical emergency would be for you. You can always call the MHS 24 hour nurse advice line at 1-877-647-4848 if you are not sure if you should go to the emergency room.

When NOT to Go to the Emergency Room

- **Flu, colds, sore throats and earaches**
- **A sprain or strain**
- **A cut or scrape not requiring stitches**
- **To get more medicine or have a prescription refilled**
- **Diaper rash**

Emergency Room Wait Times

In an emergency room, life-threatening emergencies are seen first. If you go to the emergency room for an injury or illness that is not life-threatening, you may have to wait for several hours to get seen. It is very important you see your family doctor or visit an urgent care center for non-emergencies.

Be Prepared Before an Emergency

Make sure you know the location and number of the closest emergency room to you. You can find one near you by using our "Find a Provider" search at mhsindiana.com/find-a-provider, or you can call MHS Member Services at 1-877-647-4848 and ask for a list to be mailed to you. If you have a life-threatening emergency, you can call 911 or your local emergency number to obtain emergency services. You have a right to use any hospital or other emergency setting for emergency care.

Emergency Care Follow Up

If you visit the emergency room, please give them the correct contact information for your MHS doctor. The emergency room staff will send a report to your MHS doctor that details your care plan and diagnosis. If you have to stay at the hospital, make sure you talk to the doctor on staff about why you are there. When you leave the hospital, the doctor on staff will give you instructions to follow. It is very important to follow all instructions, even if you are feeling better. The day after you go to the emergency room, or the day after you leave the hospital from an emergency admission, call to schedule a follow-up visit with your MHS doctor.

Emergency Care Coverage

Emergency room visits do not need approval from your doctor or by MHS. Emergency room visits for Hoosier Healthwise (HHW Package A) and HHW Package C (CHIP) members are covered.

Post-stabilization is a covered service you get after emergency care. This is care you receive after you are stabilized so your condition stays stable. When you visit the emergency room, the doctors and nurses must examine you and make sure you are well enough before they can allow you to leave. The doctor may decide you need other tests or services after you are stable but still at the hospital, and the doctor can call MHS to request other tests or services.

You deserve a successful medical home, where you have a place you can always go to for sick visits and regular check-ups. The doctors at the ER don't know your medical history as well as your medical home.

You must show your Hoosier Healthwise identification card each time you get medical care or go to the pharmacy. If you do not show your identification card, you may have to pay for your care. If you receive a bill for covered services or are told to file a claim, please contact MHS Member Services right away at 1-877-647-4848.

Remember to show your member ID card, and tell the staff you are an MHS member. If you do not tell them, you may get a bill in the mail. If you do get a bill, please call MHS Member Services right away at 1-877-647-4848.

Coverage for Care Outside of Indiana

Walk-In or Urgent Care

If you are out of the state and need to go to a walk-in or urgent care clinic for a problem that is not life-threatening, you must call your MHS doctor or the MHS nurse advice line at 1-877-647-4848 to get approval before you go. Otherwise, you may have to pay for the services you get at the clinic.

Emergency Care

If you are outside of Indiana and have a life-threatening emergency, go to the nearest emergency room. Emergency room coverage for care outside of Indiana is covered. Learn more about emergency care on page 30.

Care From Out-of-Plan Doctors

Out-of-plan means the doctor or facility you want to go to is not part of the MHS provider network or Indiana Medicaid network. You could be responsible for charges from unauthorized out-of-plan care if the provider is not an Indiana Medicaid Provider or if the service is not covered by your MHS plan.

MHS only covers out-of-plan care if:

- MHS does not have a doctor in-plan to provide the services you need, or does not have a doctor in-plan within 60 miles of your home
- It is for continuity of care for a pregnant member who transferred to MHS during her third trimester
- MHS authorized the out-of-plan service

Self-Referral Services

Please refer to Page 11.

American Indian and Alaskan Native Health Care Providers

Any American Indian/ Alaska Native (AI/AN) member who is eligible to receive services from a participating Indian healthcare provider can choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PMP, can choose that Indian healthcare provider as his or her PMP, as long as that Indian healthcare provider has the capacity to provide the services.

Health Management Programs

MHS has case managers who are trained to help our members with their health conditions. A case manager works with members and their family, providers, and community groups to set goals that will help you improve your health. A case manager can help you understand your benefits and treatment options and can assist with emergency housing and utility needs and other services such as rides to the doctor, food, and more.

If you or your child have or are at risk for having one of the following health conditions listed, please call so we can tell you more about our programs and help you enroll. If you would like to join a program or find out more, please call MHS Member Services at 1-877-647-4848.

You are the one taking care of you and your family. However, persons with health conditions stay healthier, longer, when they have someone in their corner. Case managers work along with your doctor to help remind you to get all of your important preventive care.

Medical Case Management Programs

- **Children with Special Needs Program**: Children with chronic conditions are eligible for this program. This includes conditions such as:
  - Cerebral palsy
  - Cystic fibrosis
  - Developmental disabilities
  - Autism
  - Traumatic brain injuries
  - Congenital syndromes with significant developmental delays
  - Other special healthcare needs

  Children enrolled in the program receive care management services by a dedicated team of MHS doctors, nurses, social workers and care coordinators, specializing in the healthcare needs of children.

- **Chronic Kidney Disease (CKD) Program**: CKD is a disease where the kidneys become less able to clean waste and extra fluid out of the blood. MHS helps you to manage risks for CKD, such as diabetes and high blood pressure. This may help keep you out of kidney replacement therapy. Our team will help you learn how to improve your diet and help you get services for the disease and its causes.

- **Congestive Heart Failure (CHF) Program**: CHF is a disease that occurs when your heart is too weak to pump blood. Our CHF program focuses on medication (drug) management. This will help lessen your chance of heart attacks, strokes, ER visits and hospitalization.

- **Coronary Artery Disease (CAD) Program**: CAD happens when a substance called plaque builds up in the arteries that supply blood to the heart (called coronary arteries). Our CAD program helps you to deal with the effects of CAD, such as chest pains, physical limitations and high cholesterol. We do this through medication (drug) management, lifestyle changes, diet and other ways to cope.

- **Diabetes ("Sugar") Program**: Diabetes is also known as "sugar." Type 1 diabetes is a disease where your body can no longer make insulin. Type 2 diabetes is a disease where your body cells are less sensitive to your insulin. Both types can cause high blood sugar levels. Please contact us if you or your child has diabetes.

- **Enhanced Asthma Management and Chronic Obstructive Pulmonary Disorder (COPD) Disease Management Programs**: Asthma cannot be cured, but most people with asthma can control their symptoms and prevent asthma attacks by avoiding asthma triggers and correctly using prescribed medicine such as inhaled corticosteroids. COPD is a group of lung diseases that cause you to have trouble breathing. Our programs will help you stay healthy by stopping acute episodes before they happen and keeping you out of the emergency room.

- **Lead Program**: Lead is a heavy metal that can be found in paint, dust, soil, water, air and food. It can be harmful to people, especially children. If your child is found to have high levels of lead in his or her blood, MHS will provide outreach and education.

Pregnancy & First Year of Life Programs

Start Smart for Your Baby® and MHS Special Deliveries

Moms who join our pregnancy programs are more likely to have a full-term pregnancy, and less likely to have a baby in the NICU. Help your baby get off to the best start!

MHS cares about your health and the health of your baby. We have two programs for MHS members who are pregnant called Start Smart for Your Baby and MHS Special Deliveries. By joining either program, you will be eligible to earn more My Health Pays® rewards. Learn more about My Health Pays® on page 38.

Start Smart for Your Baby is an educational program open to all pregnant members. MHS Special Deliveries is a care management program for pregnant members. MHS Care Managers will talk to you and suggest the program that is right for you based on your medical history and your doctor's care plan.

With either program, the MHS OB Nurses are here to make sure you get the medical care and resources you need during and after your pregnancy. MHS OB Nurses can:

- Help you understand what is happening to your body during the pregnancy
- Talk about problems that may come up during your pregnancy
- Talk about what to do if you have complications during your pregnancy
- Help you make doctor appointments or schedule a free ride to the doctor's office
- Help you get a free cell phone if you need one. You can use this phone to reach your doctor, family and other important people while you are pregnant.
- Help you quit smoking or using tobacco
- Help you find more ways to earn My Health Pays® rewards by going to your OB doctor visits
- Answer any other questions about your health and the health of your baby

We want to help you take care of yourself and your baby throughout your pregnancy. Information may be sent by mail, telephone and email and is available on our website, mhsindiana.com. A home visit with an OB nurse can also be arranged.

17P (alpha-hydroxyprogesterone caproate)
MHS offers 17P to our qualifying members with a history of preterm delivery. This drug may prevent you from having another preterm delivery. If you are identified as a candidate, we will contact your treating physician to discuss the appropriateness of using this drug.

First Year of Life
New motherhood brings many joys and surprises. It also brings many sleepless nights and changes in your life. We want our members to know the First Year of Life nursing staff at MHS is also here to give support. We can answer your questions and provide you with helpful information sheets to let you know what to expect as your baby grows. We will also call you and send reminders to schedule upcoming immunizations (shots) and well-child visits with your baby's doctor as they are needed.

Additional Programs

Birth Control Options (Family Planning)
Your birth control options are often called family planning services. This is a covered, self-referral program. That means you may go to any family planning clinic that accepts Hoosier Healthwise. However, we encourage you to get your family planning services from your doctor or another MHS doctor. If you do not feel comfortable talking to your doctor and do not know where to get these services, contact MHS Member Services at 1-877-647-4848. Either way, family planning services are private.

Right Choices Program
To protect the health of our members, MHS participates in the Right Choices Program as directed by the state of Indiana. Members are referred to the program if they are found to be using Medicaid services more than other members. These members are then assigned to one doctor and one pharmacy. They must use these specific facilities for all healthcare needs, except for in an emergency.

Members referred to the program will receive a letter from MHS welcoming them to the program. The Right Choices enrollment period may last up to two years and may be renewed for additional two-year periods upon review. However, members have the right to appeal their referral to the program within 60 days. For further questions, or if you have received a welcome letter, please call the MHS Right Choices Administrator at 1-877-647-4848.

Are you pregnant? Do you smoke? It's not too late to quit. Quitting now can make a big difference in your baby's life. The Quitline has a special program for helping women during pregnancy. Call 1-800-QUIT-NOW (1-800-784-8669).

Stop Smoking or Using Tobacco

MHS encourages you to break free from tobacco and quit smoking. Tobacco use remains the single most preventable cause of death and disease in the United States, claiming more than 480,000 lives per year. Quitting smoking can have immediate as well as long-term benefits for you and your loved ones. Let us help you today!

Call the FREE, CONFIDENTIAL Indiana Tobacco Quitline today at 1-800-QUIT-NOW (1-800-784-4669). The Quitline is an evidence-based telephone counseling program that offers one-on-one coaching to tobacco users who have decided to quit, provides professional support throughout an individual's quit continuum and discusses medication support. If you are not ready to quit, the Quitline staff will help you figure out what you can do to prepare yourself to successfully quit. Additionally, the Quitline offers a Web Coach and texting support – Text2Quit.

1.800.QUIT.NOW
Indiana's Tobacco Quitline
QuitNowIndiana.com

Plus, you can earn $100 in My Health Pays rewards by completing the Indiana Tobacco Quitline Program.

Key Program Features include:

- Counseling offered in more than 170 languages
- 24/7 access to highly-trained and dedicated Quit Coaches
- One-on-One proactive telephone counseling with a Quit Coach
- Development of a quit plan to improve your chances of success including choosing a Quit Date
- Free 2-week Nicotine Replacement Therapy starter kit (gum/patches) for those that are eligible
- Expanded services for pregnant women and youth tobacco users (13-17 years old)
- Practical advice and tips to help you cope with cravings, find ways to change your daily activities/behaviors that trigger smoking and avoid weight gain
- Enroll in the Web Coach only service to Set a Quit Date, Pick a Medication, Conquer and Control Your Urges, Control Your Environment and Get Social Support
- For additional support, enroll in the Text2Quit program to receive up to 300 text messages tailored to your quit plan

Reasons to Quit

- **Tobacco use is responsible for 1 out of every 5 deaths in the U.S.**
- **Smokers live 10 years less, on average, than non-smokers.**
- **Smokers have more health problems and visit the doctor much more than non-smokers.**
- **The average smoker in Indiana will spend more than $2,500 on cigarettes each year. That's $130,000 over a lifespan!**

There are many great reasons to quit. Ask MHS for help today.

Transportation

MHS wants to make it easy to get to the care you need. We offer FREE unlimited transportation to and from doctor visits, to fill prescriptions after a doctor visit, Medicaid redetermination appointments, WIC appointments and MHS member events. You can reach MHS' transportation vendor through MHS Member Services at 1-877-647-4848. After you are directed to the member prompt, say "transportation." You can speak to a live transportation representative between 8 a.m. - 8 p.m. Monday through Friday. Transportation is scheduled through a message system after hours and on weekends. All messages are returned within one day.

Please call to schedule your ride three (3) business days (72 hours) before your scheduled medical visit. Schedule your doctor appointment before you call to get a ride. Members can schedule a ride forty-five (45) days before their appointment. The scheduling timeframe does not include weekends, holidays, or the actual appointment date. If you need to cancel or change your appointment, call us right away to cancel or change your ride.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	Call for a ride TODAY!			Dr. Smith check-up @10 a.m.		

Here is some other information you may need to know about transportation:

- You may have up to a one-hour wait time for your ride to pick you up before your scheduled visit.
- If you need transportation due to an urgent care need, be aware it could take longer to arrive since this is not a pre-scheduled pickup. Call immediately to set up your ride.
- All transportation must be for a medical appointment that is covered by Indiana Medicaid, to pick up prescriptions after a covered medical visit, renewing your Hoosier Healthwise Medicaid coverage, or for certain MHS member events.
- If you have a life-threatening emergency, call 911 or your local emergency number.
- Children under age 16 must always ride with an adult age 18 years or older. Parent consent is generally required for minors under age 18 unless one of the exceptions in the minor consent laws apply; young adults age 18 or older generally may consent for themselves.
- MHS offers reimbursement for gas and mileage under certain conditions. Please call MHS Member Services for more information about this option.

You may take one other person along with you. Any additional riders must be approved in advance. Transportation will try to work with your situation if you request additional riders. Transportation may refuse to transport any persons who were not approved to ride in advance.

Please have the following information available when you call for a ride:

- You or your child's Medicaid card
- Your address and phone number
- The date and time of the appointment
- Name, address and phone number of the office or clinic
- Number of persons who will be riding (patient and parent or guardian only)
- Whether you will need a wheelchair-accessible van
- Whether you will need assistance to and from the door
- Whether you will need a car seat(s). If you do not have a car seat, one can be provided for you. Transportation will refuse to transport any child without the proper safety seat.

Calling for a pickup after your appointment:

- It may take from 15 minutes to one hour for a car to arrive after you call.
- Transportation can take you to a pharmacy on the way home from a doctor visit.
- Please be ready when your ride arrives.
- Transportation will pick you up at the same place they dropped you off. They cannot pick up multiple family members at different locations.

For information on gas mileage reimbursement or bus passes, please contact MHS Member Services.

If you are unsure if you should seek medical attention from an emergency room for a non-life threatening event, call your doctor's office first. If you can't reach your doctor, you can call the MHS 24 hour nurse advice line.

Transportation for HHW Package C (CHIP) Members

Non-emergent medical transportation is covered as an enhanced benefit.

Get started earning rewards today. Complete your Health Needs Screening online at mhsindiana.com/HHWscreening or call MHS Care Engagement at 1-888-252-3410.

Programs Just for MHS Members

These programs are designed to improve the health of our members through education and personal assistance by our professional staff. Call us today to ask about how to get these services we designed just for you.

my health pays®

MHS rewards members' healthy choices through our My Health Pays® program. Members can earn dollar rewards for things like screenings, preventive care and more. Use your My Health Pays® rewards to help pay for **everyday items at Walmart***, **utilities**, **transportation**, **telecommunications** (cell phone bill), **childcare services, education** or **rent**.

Get started today! You can start earning My Health Pays® rewards as soon as you become an MHS member. Complete any of the eligible healthy activities outlined below. Then reward dollars are automatically put on your My Health Pays® card. All new members are mailed a My Health Pays® card.

Earn rewards by completing the following healthy activities:

$30	Complete a health needs screening within 30 days of becoming a member.
$10	Complete a health needs screening within 90 days of becoming a member.
$15	For creating a member portal account and using your member portal account to select a PMP within 30 days of enrollment. (One per calendar year)
$10	Per infant well care visit up to 15 months old ($60 max). (These visits are recommended before 30 days old and at 2, 4, 6, 9, 12 and 15 months old)
$20	Annual well care visit with a primary care doctor. (One per calendar year; age 16 months and up)
$20	For an annual dental visit. (ages 1-20 only; one per calendar year)
$100	For completing the Indiana Tobacco Quitline Program. Call 1-800-QUIT NOW (1-800-784-8669).
$50 if within 1st trimester $25 if within 2nd trimester	Submit a Notification of Pregnancy (NOP) form to MHS. Login to your member portal account to complete your NOP.
up to $80	Participation in OB Case Management: Visit mhsindiana.com/rewards for details.
$20	Postpartum visit: See your doctor 3-8 weeks post delivery.

To check your balance, log into your secure portal account or call 1-866-809-1091.

**This card may not be used to buy alcohol, tobacco, or firearms products. This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions. Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.*

MHS SPECIAL SERVICES

MHS Healthy Kids Club
The Healthy Kids Club is a free educational program geared towards kids 12 and under. It promotes fun ways for kids to stay healthy. Kids will get a membership card and monthly e-newsletters with healthy tips and recipes. You can sign your kids up for the club at mhsindiana.com/kidsclub.

MemberConnections®
This is an outreach team of MHS staff who can help you one-on-one with understanding your health coverage and other community resources. MemberConnections can provide in-person or over-the-phone help. They will help you build a relationship with your doctor, help you understand your health benefits and put you in touch with community resources. If you are in need of transportation, food, shelter or other health programs, MemberConnections can help. Call MHS Member Services for more information at 1-877-647-4848.

Connections Plus® Cell Phone
MHS can lend a cell phone to our members enrolled in care management who do not have access to a regular phone. Connections Plus cell phones are programmed to make calls to and receive calls from the MHS Care Management team, a member's PMP, other doctors in the treatment plan, MHS 24 hour nurse advice line and family who support the member's care plan.

Member Advisory Council
MHS invites groups of our members from around the state to talk with us four times a year. Discussions include the services MHS provides and how members feel about their doctors as well as how they feel about our programs. Members also look at our print materials and website information. MHS uses this information to make program changes based on our members' feedback. If you are interested in being part of our Member Advisory Council, call MHS Member Services at 1-877-647-4848.

Call MHS MemberConnections today to help you understand your benefits, one-on-one.

Family Education Network

MHS and the Indiana Minority Health Coalition have teamed up to create the Family Education Network. The network provides face-to-face and phone benefit education to MHS members on a variety of topics. The network representatives can help explain Medicaid health plan benefits and coverage as well as an overview of MHS programs and special services available to you. Call MHS Member Services to schedule a free referral at 1-877-647-4848.

Member Ombudsman

The MHS member ombudsman program is a partnership between MHS and Mental Health America of Indiana. An ombudsman is someone who works to help you get a problem solved. MHS members can contact an ombudsman for free to discuss any problems they may be having with MHS, MHS services, MHS doctors or any other part of their healthcare. The ombudsman is neutral, so they do not side with MHS or the Medicaid program. The ombudsman will work with you to get your problem solved. If you are an MHS member (or a legal representative), please call if:

- You have questions about your MHS benefits or services.
- You want to know what your MHS rights and responsibilities are for your MHS coverage.
- You need help with the appeals process, including filling out the proper paperwork, documenting verbal appeals or guidance through the appeals process.

If you want the assistance of an ombudsman, please call them toll-free at 1-877-647-5326, 8 a.m. - 8 p.m. Monday through Friday.

OPEN ENROLLMENT & REDETERMINATION

MHS is your health coverage provider. You either chose MHS or were assigned to MHS to provide your health coverage when you joined Hoosier Healthwise or HHW Package C (CHIP). Your coverage lasts for one year. At the end of that year, you go through redetermination. This means you need to either re-apply or confirm information with the State to show that you are still eligible for Hoosier Healthwise or HHW Package C (CHIP). If approved, you continue for another year of enrollment.

We hope that you will stay with MHS through every year of your enrollment with Hoosier Healthwise. We work hard to provide the best customer service and a strong provider network, so that you can have everything you need in your health plan.

Native Americans/Alaska Natives

Native Americans/Alaska Natives have the option to opt out of managed care and receive fee-for-service coverage. If you are a Native American/Alaska Native and wish to opt out of managed care, please contact your enrollment broker.

Disenrollment Request

Members will have the opportunity to change their managed care entity (MCE) at the following intervals:

- Within ninety (90) days of starting coverage
- Once per calendar year for any reason
- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year
- At any time using the just cause process (defined below)

Just Cause Health Insurance Plan Changes

Any Medicaid member may change their managed care entity (MCE) for Just Cause. Determination as to whether a member has met one of these reasons is solely the determination of the Enrollment Broker and FSSA. The reasons include, but not limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the Contractor to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action levied against the Contractor by the office;
- 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 health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections, as described in Section 6.3.2;
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE. The enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider and, as a result, would experience a disruption in their residence or employment; or
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

To request a just cause change, please call the Hoosier Healthwise Enrollment Broker at 800-889-9949 They will answer your questions and provide you a form to request a change, if needed. Before submitting a just cause request, you must contact MHS so that we can help resolve your concern through the grievance and appeals process. If we are unable to resolve your concern after going through the MHS grievance and appeals process, you may submit a request to change your health plan to the Enrollment Broker by phone or in writing.

Redetermination

At the end of your benefit year, you will need to either re-apply or confirm information with the state to show that you are still eligible for Hoosier Healthwise or HHW Package C (CHIP) Login to the FSSA Benefits Portal at fssabenefits.in.gov or call 1-800-403-0864 to find out more.

It can take about 45 days to re-apply or confirm your information with the state. To help you, MHS will call you and send you an email to remind you when you are 45 days from your last day of eligibility.

We want to hear what you think about MHS and your care. If you get a member survey please be sure to participate!

Quality Improvement Program

MHS wants to help you get the quality care you deserve. The MHS Quality Improvement (QI) program reviews all care and services you get from MHS doctors, hospitals and other services you receive. This helps ensure the care you receive is of good quality, helpful and right for you. If you want to get more information about MHS' QI program, call us or visit mhsindiana.com where you can find:

- The MHS QI summary and program description
- Immunization information for adults and children
- Standards MHS seeks to meet and exceed
- Medical record standards and practice guidelines

Member Satisfaction Surveys

As part of the Quality Improvement program, every year some members are asked to answer a survey to tell us about the care and services they receive from MHS and MHS doctors. MHS shares the survey answers with MHS doctors and uses the information to help improve member care and how we communicate with you. Your answers to these surveys are always anonymous, meaning we do not know who answered the survey. If you get a survey in the mail or over the phone, please take the time to answer and return the survey. It will help make MHS and the state healthcare programs the best they can be for you and your family.

Provider Qualifications

You have the right to see information about your doctor, specialist or other provider. You can find a provider's name, address, telephone number, professional qualifications, specialty and board certification status using our Find-A-Provider tool at mhsindiana.com. For information about a provider's medical school or residency, call Member Services. Our lists are updated any time there is a change. Or you can call us and ask for a list of providers to be mailed to you.

COMPLAINTS, GRIEVANCES AND APPEALS

We hope our members will always be happy with MHS and our providers. Please tell us if you are not satisfied with MHS programs and services or services provided by your doctor, or if you disagree with a decision that MHS made regarding your healthcare. We have steps for handling any problems you might have.

Complaints

To make a complaint, call MHS Member Services at 1-877-647-4848. MHS takes your complaints seriously. We record your complaint and follow up with you about how we can serve you better. MHS will respond to your complaint with an outcome within one (1) business day. If you are unhappy with how your complaint is handled or if it took more than one (1) business day, your complaint will turn into a grievance.

Grievances

You or your authorized representative can file a grievance about your concern at any time. Grievances can be filed with MHS in the following ways:

Writing: MHS Appeals, P.O. Box 441567, Indianapolis, IN 46244
Orally: MHS Member Services, 1-877-647-4848
In Person: 429 N Pennsylvania St., Suite 109, Indianapolis, IN 46204
Online on the Secure Member Portal: www.mhsindiana.com/members.html

A written grievance needs to include:

- Your name, phone number, address and signature.
- Your member identification number.
- The reason(s) why you are unhappy.
- How MHS can help.

You can present copies of papers that help support your case in person or in writing.

MHS will send you a letter within three (3) business days to tell you we have your grievance on file. The letter includes your rights and the next steps you can take. All grievances are resolved within 30 calendar days. The resolution is sent to you in writing within 30 calendar days. MHS may ask for an extra 14 calendar days to make a decision. If we need more time, we will let you know in writing before the 30-calendar day deadline. You may request an expedited grievance if you believe a standard grievance could seriously jeopardize your life or prevent your ability to regain maximum function. You can file a grievance if you disagree with the extension.

If you are not happy with the resolution, you have the right to appeal.

Appeals

An appeal is when you, your provider or your representative are not satisfied with the result of a decision made by MHS and wish to take action. This may be because you are not happy with the results of a grievance you filed, OR because you are not happy with a decision MHS made when your doctor asked for prior authorization or prior approval for some treatment, therapy, medical equipment or other medical service. To name a representative or your provider, send MHS a signed letter or consent form telling us who will be your representative.

Appeals need to be filed within 60 calendar days from the date on the letter telling you about the decision. You or your representative may write, phone, fax or email the appeal request and consent (if a representative) to:

Written: MHS Appeals, P.O. Box 441567, Indianapolis, IN 46244
Phone: MHS Member Services or MHS Appeals at 1-877-647-4848
Fax: 1-866-714-7993
Email: appeals@mhsindiana.com

Your written appeal should include:

- Your name, phone number, address and signature
- Your member identification number
- The reason(s) why you are unhappy
- How you want MHS to help

You can present copies of papers that support your case in person or in writing.

MHS will write to you within three business days to say we received your request. Your case will be assigned to a person with the right qualifications to review your case, such as a physician or administrative manager. The person assigned will not have been involved in the original decision or the decision at the previous review.

All appeals are resolved within 30 calendar days. The result is sent to you in writing within 30 calendar days. MHS may ask for an extra 14 calendar days to make a decision. If we need more time, we will let you know in writing before the 30 calendar day deadline.
If you are not happy with the result of your appeal, you may have the right to an external, independent review.

Expedited Review
If waiting the regular time for the answer to the appeal would put you at risk of serious bodily harm or injury, you may ask MHS to consider doing an extra fast review. This is called "expedited review." To ask for expedited review, call or write to MHS as soon as possible. MHS resolves expedited reviews within two calendar days (48 hours).

External, Independent Review and State Fair Hearing

External, Independent Review
External, independent reviews may be requested for decisions made by MHS Medical Management or MHS Utilization Management:

- Based on medical necessity, or
- The service being requested is experimental or investigational

Before requesting review, member must complete grievance and appeal process. To request a review, call or write to MHS within 120 calendar days of your appeal decision. MHS will send the complete case file to an external, independent review agency that is registered with the Indiana Department of Insurance and has no connection to MHS. The independent review agency will have a same-specialty physician review the case. They will send their answer to the member and to MHS within 72 hours for an expedited appeal, or 15 business days for a standard appeal. MHS will pay for this review. A member may seek external review by an IRO, and such process may run concurrently with a State fair hearing.

State Fair Hearing
You may ask for a State Fair Hearing at the Indiana Family and Social Services Administration. For help requesting a State Fair Hearing write to the FSSA directly within 120 calendar days of exhausting MHS appeal procedures:

Office of Administrative Law Proceedings
100 N. Senate Avenue, Room N802
Indianapolis, IN 46204-2273

Care During Appeals
You are still our member during an appeal. You will continue to get all covered healthcare services for your benefit package. And MHS will continue to cover the care you are appealing until the final decision is made. If the final decision on your appeal is to deny the services, you may have to pay for those covered services.

Your Appeal Rights and Choices

If MHS makes a decision about your care and you disagree, as an MHS member, you have a right to ask us to review the decision:

- You may write or call MHS to file an appeal and ask us to review the decision. You must contact us within 60 calendar days from the date MHS made its decision. If you miss that deadline, you will not be able to have the case reviewed.
- You may ask MHS to help you. If you call us, MHS will help you by filling out a member appeal.
- You may send MHS medical documentation, statements or other evidence, or any allegations of fact or conclusions of law you think we should know. You may ask your treating physician or your primary care doctor to send us information you think we should have.
- You may ask someone to represent you, like your doctor or a lawyer, a family member or another person you trust. To name a representative, send MHS a signed letter or note telling us the name of the person, your relationship with the person, and how to call or write to them. You don't have to name a representative if you don't want to.
- If you believe waiting the regular time for the answer to your appeal will harm your life or health, you may ask MHS to consider doing an extra-fast review of your case, called an "expedited review." You must ask for this as soon as possible by calling or writing to MHS.
- You may participate in resolving your case by contributing paperwork you would like reviewed and by meeting with the panel reviewing your case, either in person or on the phone. You must let us know your plan to participate in advance when you call or write to us. You may have the person you named to represent you join you in participating in the resolution of your case.
- You may review any medical records MHS has on file for you, and you may review your case file both before and during the appeal process, free of charge. To ask to see the information, please call or write to MHS.
- You may contact MHS Member Services to check on the status of your case by phone at 1-877-647-4848 or online at mhsindiana.com/contact-us.
- If you are not satisfied with the results of the MHS review of your case, you have the right to go to the next level of appeal including Independent Review, State Fair Hearing, or both.

Medical Decisions

MHS providers and staff make decisions about treatments for our members based on providing the best care and service possible. MHS does not reward any provider, doctor or member of their staff for denying or reducing services or payment. MHS does not reward or pay doctors or MHS staff to keep you from getting less care than you need.

MHS does not make coverage decisions based on moral or religious beliefs. You may have a request that a certain doctor or hospital cannot follow because of their moral or religious beliefs. If that happens, that doctor or hospital should tell you so you can decide if you want a different doctor or hospital to care for you. If you have an advance directive (see this section) and your doctor does not follow your wishes, you can file a complaint with the Indiana State Survey and Certification Agency.

Doctor Incentives

MHS provides incentives for doctors based on the quality of healthcare provided to our members. For example, pediatricians are encouraged to make sure children get immunizations (shots). We do not give incentives to MHS doctors for not providing care. For more detailed information about MHS' incentive plans for doctors, please call MHS Quality Improvement at 1-877-647-4848.

Advance Directives

Advance directives refer to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives. Advance directives are normally one or more documents that list your health care choices for when you cannot make the choices for yourself. 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. There are many ways to make advance directives:

- Talk to your doctor and family
- Choose someone to speak or decide for you, known as a health care representative
- Power of Attorney and/or Living Will

For more information about your rights under Indiana law you can visit the Indiana State Department of Health website at https://www.in.gov/isdh/25880.htm

New Treatments and Technologies

MHS has a group of physicians and staff who regularly look at new services, treatments and drugs that become available to help make sure you get good care.

Notice about MHS as a Second Payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

MHS has the right and the responsibility to collect payment for covered services when someone else has to pay first.

MHS' Right of Subrogation

Subrogation is the process by which MHS gets back some or all of the costs of your healthcare from another insurer or responsible party. Examples include:

- Your motor vehicle or homeowner's insurance
- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' compensation

Notice about MHS as a Second Payer (cont'd)

If an insurer other than MHS should pay for services related to an illness or injury, MHS has the right to ask that insurer to repay us. MHS is subrogated to any right of recovery you have against a third person who caused your illness or injury, or any right of recovery you have against another insurance plan, including but not limited to any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, no-fault automobile insurance coverage or any other first party insurance coverage. Unless otherwise required by law, coverage under this policy by MHS will be secondary when another plan, including another insurance plan, provides you with coverage for healthcare services.

MHS' Right of Reimbursement

If you get money from a lawsuit or settlement for an illness or injury, MHS has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

Your Responsibilities

As a member of MHS, you agree to:

- Let us know of any events that may affect MHS' rights of subrogation or reimbursement.
- Cooperate with MHS when we ask for information and assistance with coordination of benefits, subrogation, or reimbursement.
- Sign documents to help MHS with its rights to subrogation and reimbursement.
- Authorize MHS to investigate, request and release information, which is necessary to carry out coordination of benefits, subrogation, and reimbursement to the extent allowed by law.
- Pay all such amounts to MHS recovered by lawsuit, settlement or otherwise from any third person or his or her insurer, or from your insurer, including but not limited to any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, no-fault automobile insurance coverage or any other first party insurance coverage to the extent of the benefits provided under the coverage, up to the value of the benefits provided.
- If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys' fees, in enforcing our rights under this plan.

Waste, Fraud And Abuse Of The Program

Preventing and limiting waste, fraud and abuse helps protect the healthcare programs that serve you and your family. If you think a plan member or a provider has committed waste, abuse or fraud, you have a right and a responsibility to report this. Examples of member fraud or abuse include:

- A member who lets someone else use their member ID card to get medical care
- A member who seeks to have the plan pay for drugs he or she does not need

Examples of provider fraud or abuse include:

- A provider that orders unnecessary tests.
- A provider that orders DME that you do not need.

Your safety and well-being are very important to us. If you or your family has any concerns, please call us right away. If you think a provider, member or another person is misusing the program, tell us immediately. MHS is serious about finding and reporting waste, fraud and abuse. Call our confidential toll-free hotline at 1-866-685-8664. You may also call the Indiana Family and Social Services Administration confidential, toll-free hotline at 1-800-403-0864. You will not need to give your name.

MHS MEMBER RIGHTS & RESPONSIBILITIES

As an MHS member, you have the right to …

- Receive information about MHS, as well as MHS services, practitioners, providers and your rights and responsibilities. We will send you a member handbook when you become eligible and a member newsletter four times a year. In addition, detailed information on MHS is located on our website at mhsindiana.com. Or you may also call MHS Member Services at 1-877-647-4848.
- Obtain information about the structure and operation of MHS
- Be treated with respect and with due consideration for your dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- A candid discussion of appropriate or medically-necessary treatment options, regardless of cost or benefit coverage
- Participate with practitioners in decisions regarding your healthcare, including 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 regulations on the use of restraints and seclusion
- Request and receive a copy of your medical records, and request they be amended or corrected as allowed in federal healthcare privacy regulations
- Voice complaints, grievances or appeals about the organization or the care it provides
- Make recommendations about our Member Rights and Responsibilities policy
- An ongoing source of primary care appropriate to your needs and a person formally designated as primarily responsible for coordinating your healthcare services
- Personalized help from MHS staff so you can ensure you are getting the care needed, especially in cases where you or your child have "special healthcare needs" such as dealing with a long-term disease or severe medical condition. We make sure you get easy access to all the care needed and will help coordinate the care with multiple doctors and get case managers involved to make things easier for you. If you have been determined to have a special healthcare need by an assessment under 42 CFR 438.208(c)(2) that requires a course of treatment or regular care monitoring, we will work with you to provide direct access to a specialist as appropriate for your condition and needs.
- Have timely access to covered services
- Have services available 24 hours a day, seven days a week when such availability is medically necessary
- Get a second opinion from a qualified healthcare professional at no charge. If the second opinion is from an out-of-network provider, the cost will not be more than if the provider was in-network.
- Direct access to women's health specialists for routine and preventive care, including family planning, annual women's tests and OB service, without approval by MHS or your MHS doctor. This includes birth control, HPV tests, chlamydia tests and annual Pap smears.
- Receive written notice of a decision to deny a service authorization request or to authorize a service in an amount, duration or scope less than requested. You will receive this information as quickly as needed so your medical needs are met and treatment is not delayed. We will not jeopardize your medical condition waiting for approval of services. Authorizations are reviewed based on your medical needs and made in compliance with state timeframes.

As an MHS member, you have the responsibility to …

- Provide information (to the extent possible) needed by MHS, its practitioners and other healthcare providers so they can properly care for you
- Follow plans and instructions for care which you have agreed to with your MHS doctors
- Understand your health problems and participate in developing mutually-agreed-upon treatment goals to the degree possible

WORDS AND ACRONYMS TO KNOW

Benefit	Health care service coverage that a Medicaid member receives for the treatment of illness, injury, or other conditions allowed by the State.
Case Management	MHS programs for members with special health conditions that help members manage their conditions by routine contact and help from MHS.
Children's Health Insurance Program HHW Package C (CHIP)	A part of the Balanced Budget Act of 1997 that includes an expansion of the Medicaid program that extends coverage to children ages zero to 19 years old whose family income is the Federal Poverty Level (FPL). CHIP is also known as Hoosier Healthwise Package C.
Cost Sharing	The costs a member is responsible for paying for health services when covered by health insurance.
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. Members can call an enrollment broker at 800-889-9949.
Eligible Member	Person certified by the State as eligible for medical assistance.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment Services. These are a series of tests your child needs to receive from birth to age 21 to help them to keep from getting sick or to detect potential health problems early so they can be treated.
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 and Planning, the Division of Aging, the Division of Family Resources, Office of Early Childhood and Out-of-School Learning, Indiana 211, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.
Health Needs Screening (HNS)	A questionnaire members must complete within 90 days of MHS membership so MHS is aware of the individual's healthcare conditions. This allows MHS to match members' needs with the right programs and services.
Hoosier Care Connect (HCC)	Hoosier Care Connect is a health care program for individuals who are aged 65 years and older, blind, or disabled and who are also not eligible for Medicare.
Hoosier Healthwise (HHW)	Indiana's Medicaid health care program for children up to age 19 and pregnant women.
Healthy Indiana Plan (HIP)	The Healthy Indiana Plan is an affordable health insurance program from the state of Indiana for uninsured adult Hoosiers age 19 - 64.
Indiana Health Coverage Programs (IHCP)	The name used to describe all of Indiana's public health assistance programs, such as Medicaid, HIP and HHW Package C (CHIP).
Income	In terms of eligibility, money that you earn through a job, self-employment (earned income), or money that is paid to you directly, such as SSI or SSDI (unearned income).
LCP	The company MHS uses to provide transportation to eligible members.
MHS	Managed Health Services, abbreviated MHS
Medicaid	A program that offers health insurance to certain low-income families, individuals with disabilities, and elderly individuals with limited financial resources. Medicaid is jointly funded by the federal and state government.
Medically Necessary	Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

WORDS AND ACRONYMS TO KNOW

Member	A person who has chosen MHS as their health coverage plan and gets their benefits through MHS.
MHS Nurse Advice Line	MHS Nurse Advice Line is MHS' medical advice phone line staffed by registered nurses. MHS Nurse Advice Line is open 24 hours a day, every day of the year. Members can call 1-877-647-4848.
OTC	Over-The-Counter; refers to medications such as cold medicine and aspirin that can be purchased without a prescription.
PDL	Preferred Drug List. Your pharmacy benefit has a Preferred Drug List (PDL). The PDL shows some of the drugs covered under the pharmacy benefit.
PHI	Protected Health Information. This is information about you and your health that must be maintained securely and is subject to laws that detail who can see the information and under what circumstances.
PMP	Primary Medical Provider, your MHS doctor. A pediatrician, general practitioner, family practitioner, internist or sometimes an obstetrician/gynecologist who has contracted with MHS to provide primary care to members and to refer, authorize, supervise and coordinate the provision of benefits. Nurse practitioners and physician's assistants associated with a contracted primary medical provider may see members seeking primary care.
Prior Authorization (PA)	A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.
Prior Claims Payment Program	The Prior Claims Payment Program is targeted to individuals eligible through Section 1931, and reimburses providers for costs of services provided prior to their effective date of coverage. Call 800-457-4584 to check availability.
Provider	Any medical, dental or behavioral health professional who may provide care for our members. Most often it refers to physicians (doctors).
Recipient Identification Number (RID)/ Member Identification Number (MID)	The unique number assigned to a member who is eligible for Medicaid services. This number can be found on the front of your Medicaid ID card.
Self-Referral	A covered service a member can get without having the approval of their MHS doctor, MHS or anyone else. A member may self-refer for special services that do not require pre-service review by MHS or the Primary Medical Provider (PMP).

NOTICE OF PRIVACY PRACTICES

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

Effective 5/2/24

For help to translate or understand this, please call 1-877-647-4848 (TTY 1-800-743-3333).

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-877-647-4848 (TTY 1-800-743-3333).

Covered Entity's Duties:
Managed Health Services (MHS) is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MHS is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

MHS reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. MHS will promptly revise and distribute this Notice whenever there is a material change to the following:
- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written, and Electronic PHI
- MHS protects your PHI. We are also committed in keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. We have privacy and security processes to help.
- These are some of the ways we protect your PHI:
- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI
The following is a list of how we may use or disclose your PHI without your permission or authorization:

Treatment — We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.

Payment — We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.

Healthcare Operations — We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:
- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals
- Case management and care coordination
- Detecting or preventing healthcare fraud and abuse

Your race, ethnicity, language, sexual orientation, and gender identity are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with health care providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

This information helps us to:
- Better understand your healthcare needs.
- Know your language preference when seeing healthcare providers.
- Providing healthcare information to meet your care needs.
- Offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

Group Health Plan/Plan Sponsor Disclosures — We may disclose your PHI to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI

Fundraising Activities — We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Underwriting Purposes — We may use or disclose your PHI for underwriting purposes, such as to decide about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

Appointment Reminders/Treatment Alternatives — We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

As Required by Law — If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

Public Health Activities — We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.

Victims of Abuse and Neglect — We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect, or domestic violence.

Judicial and Administrative Proceedings — We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.

Law Enforcement — We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.

oroners, Medical Examiners, and Funeral Directors — We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

Organ, Eye, and Tissue Donation – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.

Threats to Health and Safety — We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

Specialized Government Functions — If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, the U.S. Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.

Workers' Compensation — We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Emergency Situations – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

Inmates — If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

Research — Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization
We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:
Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment, or healthcare operation functions.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individuals Rights
The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

Right to Request Restrictions — You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

Right to Request Confidential Communications — You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

Right to Access and Receive a Copy of your PHI — You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.

Right to Amend your PHI — You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision, and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive an Accounting of Disclosures — You have the right to receive a list of instances within the last six-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

Right to File a Complaint — If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019 (TTY: 1-800-537-7697) or visiting hhs.gov/ocr/privacy/hipaa/complaints.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

Right to Receive a Copy of this Notice — You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our website or by electronic mail (email), you are also entitled to request a paper copy of the Notice.

Contact Information

Questions about this Notice: If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone by using the contact information listed below.

MHS
Attn: Privacy Official
429 N Pennsylvania St., Suite 109
Indianapolis, IN 46204
1-877-647-4848
(TTY: 1-800-743-3333)

STATEMENT OF NON-DISCRIMINATION

Managed Health Services (MHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHS:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact MHS at 1-877-647-4848 (TTY/TDD 1-800-743-3333).

If you believe that MHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievance and Appeals Coordinator, MHS, P.O. Box 441567, Indianapolis, IN 46244, 1-877-647-4848 (TTY/TDD 1-800-743-3333), Fax 1-866-714-7993. You can file a grievance by mail, fax, or email. If you need help filing a grievance, MHS is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

LANGUAGE TAGLINES

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de MHS, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Chinese:	如果您，或是您正在協助的對象，有關於 MHS 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-647-4848 (TTY/TDD 1-800-743-3333)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu MHS hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-647-4848 (TTY/TDD 1-800-743-3333) an.
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich MHS, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Burmese:	သင် သို့မဟုတ် သင်မှကူညီနေသူတစ်ဦးဦးတွင် MHS အကြောင်း မေးစရာများရှိပါက အခမဲ့အကူအညီ ရယူပိုင်ခွင့်နှင့် သင်၏ဘာသာစကားဖြင့် အချက်အလက်များကို အခမဲ့ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်တစ်ဦးနှင့် စကားပြောဆိုရန် 1-877-647-4848 (TTY/TDD 1-800-743-3333) ကို ဖုန်းဆက်ပါ။
Haitian Creole	Si ou menm, oswa yon moun w ap ede, gen kesyon sou MHS, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou kapab pale ak yon entèprèt, rele nan: 1-877-647-4848 (TTY: 1-800-743-3333).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول MHS، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-877-647-4848 (TTY/TDD 1-800-743-3333)
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 MHS 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-647-4848(TTY/TDD 1-800-743-3333)로 전화하십시오.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về MHS, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-647-4848 (TTY/TDD 1-800-743-3333).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'MHS, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Japanese:	MHS について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-647-4848 (TTY/TDD 1-800-743-3333) までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over MHS, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877-647-4848 (TTY/TDD (teksttelefoon) 1-800-743-3333) om met een tolk te spreken.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa MHS, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования MHS вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-647-4848 (TTY/TDD 1-800-743-3333).
Punjabi:	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਸਿ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿੱਚ MHS ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-877-647-4848 (TTY/TDD 1-800-743-3333) 'ਤੇ ਕਾਲ ਕਰੋ।
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, MHS के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी परापत करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-877-647-4848 (TTY/TDD 1-800-743-3333) पर कॉल करें।

NOTES

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