more than $2,500, the first $2,500 is covered by their POWER Account, and additional health services are fully covered at no additional cost to the members.

What are the Healthy Indiana Plan health plans?

There are four managed care entities (health plans) that manage the benefits and POWER Accounts of Healthy Indiana Plan members. They are Anthem Blue Cross and Blue Shield, CareSource Indiana, Managed Health Services and MDwise.

What are the benefits of HIP Plus?

The HIP Plus program provides comprehensive benefits including vision, dental and chiropractic services for a low, predictable monthly cost. With HIP Plus, members won't have to pay every time they visit a doctor or fill a prescription. HIP Plus allows members to make a monthly contribution to their POWER Account based on their income. If both the member and spouse are enrolled in HIP Plus, the monthly contribution amount will be split between the two. The only other cost for health care in HIP Plus is a payment of $8 if members visit the Emergency Room when they *do not* have an emergency health condition.

Can the member receive help paying for the required contribution?

Yes, in the Healthy Indiana Plan, third parties such as employers, nonprofits and friends or family can contribute any amount up to the full contribution amount. In addition, the health plans may implement a rewards program that allows members to "earn" additional dollars in their POWER Accounts. Total contributions may not exceed the members' required contribution to their POWER Accounts.

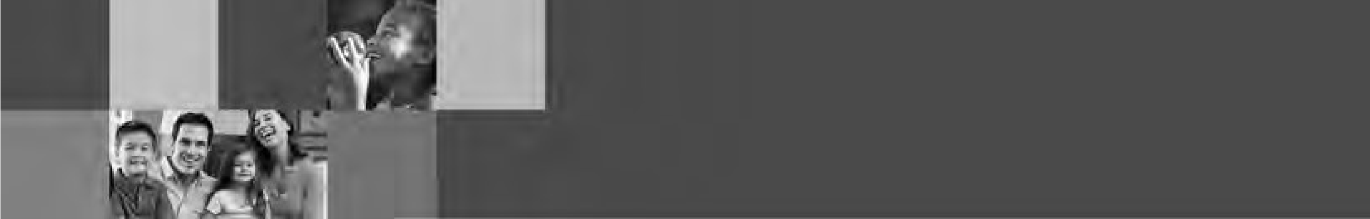
How does someone find a provider? Can he or she keep the same doctor?

Healthy Indiana Plan members should call their health plan (Anthem, CareSource, MDwise or MHS) or go online to research which providers are in that health plan's network. Members can also call **877-GET-HIP-9** and ask.

Members new to HIP will want to make sure they choose a health plan that includes their doctor. They can call **877-GET-HIP-9** to discuss options.

■ Hoosier Care Connect

Hoosier Care Connect is a coordinated care program primarily serving Hoosiers age 65 and over, or with blindness or a disability who live in the community and are not eligible for Medicare or for home- and community-based waiver services. Children who are wards of the state, are in the Adoption Assistance Program, as well as those who are current and former foster children can opt into Hoosier Care Connect rather than receive traditional Medicaid. In Hoosier Care Connect, a person enrolls with a health plan that provides most of their



Medicaid-covered benefits. A health plan, also called a managed care entity, is a group of doctors, pharmacies and hospitals that work together to help an individual get the health services he or she needs.

What is covered by Hoosier Care Connect?

Hoosier Care Connect provides standard benefits including coverage for medical expenses such as doctor visits, hospital care, therapies, medications, prescriptions and medical equipment. The benefits also include preventative care, such as regular check-ups, and mental health and substance abuse treatment. Hoosier Care Connect also has benefits for members with certain health care conditions like heart disease, asthma, diabetes or a disabling condition. Various health plans may offer additional services.

Services that do not need a doctor's referral:

- Dental care
- Podiatry care (foot care)
- Chiropractic care
- Vision/eye care (except surgery)
- Mental health services
- Substance abuse services
- Transportation services

If members need any other special service or need to see another type of medical professional, they need to talk with their doctor to get a referral. Some services will require their doctor or other specialty provider to request prior authorization before the service can be delivered. It is up to the provider to request the prior authorization.

How does someone choose a health plan and a health care provider?

When applicants enroll in Hoosier Care Connect, they will select a health plan. Each health plan has a network of health care providers including primary care doctors, specialists, home health providers, pharmacies, therapists, etc.

It is important for applicants to know which health plans their doctor or doctors participate in. For most health care services, applicants must use the health care providers who are in their health plan.

The health plan choices are:

- Anthem
- Managed Health Services
- United Healthcare

How do applicants know if they are eligible?

The Eligibility Guide, found under the "Apply for Coverage" tab at **in.gov/medicaid/members**, is a resource tool that can provide eligibility information to assist individuals in knowing if they are more likely or less likely to qualify for any Medicaid benefits. It is not a final determination. The only way to know eligibility is to apply.