NAHU CE Reciprocity

1. Each “home state” Professional Development Chair should furnish the requesting state the following information. (Samples are included in this packet.)
    a. Letter of permission for requesting state to file the course(s).
    b. Course Description
    c. Course Outline, with Time Frames
    d. Copy of Approval Certificate from State
    e. PowerPoint Presentation with Notes
2. Included in this packet is the NAIC CE Reciprocity Approval Form.

UNIFORM CONTINUING EDUCATION RECIPROCITY COURSE FILING FORM

Please clearly print or type information on this form. Thank you for helping us promptly process your application.

Provider Information

Provider Name		FEIN # (if applicable)			
Contact Person	E-mail Address of Contact Person				
Phone Number ( ) - ext.	Fax Number ( ) -	Home State	Home State Provider #	Reciprocal State	Reciprocal State Provider #
Mailing Address		City		State	Zip

Course Information

Course Title

Date of Course Offering (if applicable)

Method of Instruction			National Course
Self – Study (non-contact)	**Classroom (contact)**		
☐ Correspondence	☐ Seminar/Workshop		**National Insurance Designation?**
☐ On-Line Training (Self-Study)	☐ Webinar		☐ Yes ☐ No
☐ Video/Audio/CD/DVD	☐ Teleconference		Designation Type:
Word Count _____	☐ Other _____		_____
Difficulty (Circle) Basic Intermediate Advanced			**Is this Course Open to the Public?**
Examination Required?	☐ Yes	☐ No	☐ Yes ☐ No

Credit Hours Requested and Course/Hours Decision

Course Concentration	Hrs Requested by Provider		Hrs Approved by Home State		Hrs Approved by Reciprocal State	
	Sales/Mktg	Insurance	Sales/Mktg	Insurance	Sales /Mktg	Insurance
A. Insurance Topics: (Circle Appropriate Course Concentration)						
Life / Health						
Property / Casualty/Personal Lines						
Ethics						
General (Applies to all lines)						
Insurance Laws						
Other (LTC, NFIP, Viatical, Annuities, _____)						
Total Hours						
B. Adjuster Topics (Total Hours)						

Information Below is for Regulator Use Only

Approval Date			
Course Number assigned			
Course approval expiration date			
Signature of Home State Regulator/Representative **OR** ATTACH Provider Home State Approval Form			
Signature of Reciprocal State Regulator/Representative **OR** ATTACH Reciprocal State Approval Form			

See State Matrix for Instruction Sheet and State Specific Fee Schedule

SAMPLE PERMISSION LETTER

Indiana State Association of Health Underwriters (ISAHU)
c/o Marlene H. Bowen
8245 Woodbriar Drive
Evansville, IN 47715

March 15, 2010

State Assn. wishing to file CE Reciprocity
c/o Professional Dev. Chair
Street Address
City, ST ZIP

Dear _____:

This is to inform you as, the Professional Development Chair of the _____ State Association of Health Underwriters, your State Association is permitted to file ISAHU's course, *Healthy Indiana Plan* (IN DOI # 17738), for CE approval in your state. You are permitted to use the course for unlimited presentations in your state's chapters.

Sincerely,

Marlene H. Bowen
ISAHU Professional Development Chair
Indiana Provider # 104204

SAMPLE COURSE DESCRIPTION

Healthy Indiana Plan (HIP)

ISAHU Course #17738

IN DOI approved for One (1) hour Continuing Education

This course provides an overview of the Healthy Indiana Plan (HIP), including what it is and how it was developed. The course also explains in detail the coverage offered by the plan, what the POWER account is and how it works, who may qualify for coverage under the plan, and the applicants' responsibilities under the plan.

SAMPLE CE OUTLINE

Healthy Indiana Plan (HIP)

I. ***(5 minutes)*** Overview of HIP
- A. State-sponsored health insurance plan for uninsured low-income Hoosiers
- B. First State in the nation to implement a CDHC program for Medicaid beneficiaries; watched closely by other states for potential replication
- C. Based on four guiding principles:
- D. Not an entitlement program

II. ***(10 minutes)*** HIP Qualifications
- A. No other coverage available
- B. Age limitations
- C. Income limitations

III. ***(20minutes)*** HIP Coverage
- A. Guaranteed issue for subsidized plans; underwritten for over 200% FPL
- B. Coverage term 12 months; re-certification each year
- C. Covers essential medical services; limited benefits with incentives to use health care services efficiently - inspired by HSA model.
- D. POWER account
- E. Co-pays - No co-pays except for ER use if not deemed true emergency
- F. Pregnancy - No pregnancy related procedures are covered under HIP
- G. Contributions
- H. Switching Plans
- I. Coverage Start Date

IV. ***(15 minutes)***Available Plans - 2 Insurers + ESP
- A. Anthem
- B. MDWisewith AmeriChoice
- C. Enhanced Services Plan (ESP)

STATE OF INDIANA

MITCHELL E. DANIELS, JR., Governor

IDOI

INDIANA DEPARTMENT OF INSURANCE
311 W. WASHINGTON STREET, SUITE 300
INDIANAPOLIS, INDIANA 46204-2787
TELEPHONE: (317) 232-2385
FAX: (317) 232-5251

JAMES ATTERHOLT, Commissioner

Friday, January 9, 2009

MARLENE BOWEN
IN STATE ASSN HEALTH UNDERWRITERS
8245 WOODBRIAR DR.
EVANSVILLE, IN 47715

This letter serves as formal approval of your recent course submission by the Insurance Agent Education Advisory Council.

PROVIDER NO:	**104204**
COURSE NO:	**17738**
COURSE TITLE:	**HEALTH INDIANA PLAN**
COURSE HOURS:	**1**
INSTRUCTION METHOD:	**CLASSROOM**
EXPIRATION DATE:	**1/31/11**

PROVIDER WILL NOT BE NOTIFIED OF COURSE EXPIRATION.

Please note that the Provider is responsible to ensure that attendance roster information is submitted electronically within 10 days from the date of the course completion.

New Providers must sign up with Sircon and electronically update their continuing education Subsequent Offering locations and dates in "real time" using Compliance Express. Subsequent offerings must be input at least 30 days prior to the time each course is offered.

Judy Canfield
CE Coordinator

HEALTHY INDIANA PLAN (HIP)

Indiana State Association of Health Underwriters

Overview of HIP

- IN HOUSE ENROLLED ACT No. 1678; 2007
- State-sponsored health insurance plan for uninsured low-income Hoosiers
- First State in the nation to implement a CDHC program for Medicaid beneficiaries; watched closely by other states for potential replication

The Indiana legislators passed into law the House Enrolled Act 1687, in 2007. This Act included provisions for the Healthy Indiana Plan, better known as HIP, a state-sponsored health insurance plan for uninsured low-income Hoosiers.

This is the first state-sponsored Consumer Directed Health Plan for low-income, uninsured residents. Indiana was able to adopt the CDHC model because our Family Social Services Agency (FSSA) chose to work with professional, knowledgeable people when they designed the plan – specifically members of the Indiana State Association of Health Underwriters.

ISAHU feels it is imperative to educate our members on HIP because….

- ISAHU members are THE resource for health insurance - our members may be the best source of information for Hoosiers that qualify for HIP;
- Consumers with questions on HIP should not have to rely only on the providers, such as hospitals, who are offering information. Many of those asking about HIP may not qualify for the subsidized plan and ISAHU members are able to offer alternative solutions to meet their needs.
- As of Dec 2008 only 41,948 Hoosiers were enrolled in HIP (half were childless adults). ISAHU members need to help spread the word about the HIP program to aid in its success and prevent replacement with a program such as a "single payer system";
- In August 2008, the buy-in option was implemented for people who exceed income limits for HIP's subsidized program. With monthly premiums ranging from $125 for a 25-year-old male to $550 for a 60-year-old female, many of these applicants may have better options available to them in the private market.

And because Indiana is the first State in the nation to implement a CDHC program for Medicaid beneficiaries, it will be watched closely by other states for potential replication.

Overview of HIP

- Based on four guiding principles:
  1. Personal Responsibility
  2. Fiscal Responsibility
  3. Promoting Healthy Behaviors
  4. Promoting the Appropriate Use of Health Care Services

HIP was based on four guiding principles:

1. Personal Responsibility - HIP requires each participant to make a modest financial contribution, promoting the notion of consumerism. While contributions are higher than traditional Medicaid premiums, participants have total control over how these dollars are spent.

2. Fiscal Responsibility - The required individual contributions assures that participants are "buying into" the concept and will control their healthcare spending. And the government's contribution is completely funded through an increase in the State's cigarette tax. In addition, the legislation restricts the State from providing services "beyond the level of state appropriations authorized for the plan."

3. Promoting Healthy Behaviors - HIP members, i*f they have received requisite preventive services,* can apply year-end balances to offset future contributions. This transforms Medicaid beneficiaries into consumers with an incentive to seek necessary preventive services and maintain a healthy lifestyle.

4. Promoting the Appropriate Use of Health Care Services - By giving participants some "skin in the game," HIP provides individuals the financial incentives to make cost- and value-conscious healthcare decisions. POWER Accounts are designed to encourage preventative care, the appropriate utilization of health care services, and personal responsibility.

Overview of HIP

- Not an entitlement program
  - Enrollment limited by the available funding, so benefits and participation is limited
  - Currently only enough funding to cover about 130,000 Hoosiers
  - Requires each participant to make a modest financial contribution – not totally free to applicants

You see, **HIP is not an entitlement program**. Enrollment is limited by the available funding, so benefits and participation is limited unlike traditional Medicaid. In fact, it is estimated that there is currently only enough funding to cover about 130,000 Hoosiers. But what really makes HIP different from Medicaid is that it requires each participant to make a modest financial contribution – so it is not totally free to applicants. The applicants actually have some of their own "skin in the game".

HIP Qualifications

- No other coverage available - goal to reduce the number of uninsured in Indiana
  - Uninsured for six months, other than COBRA or limited benefit plans
  - Cannot be eligible for coverage through employer sponsored plan

Because the goal of HIP is to reduce the number of uninsured in Indiana, in order to qualify for HIP, an individual must not have had insurance coverage for at least six months, other than COBRA or limited benefit plans such as accident only or disease specific. In addition they cannot be currently eligible for coverage through an employer sponsored plan, and they cannot be disabled.

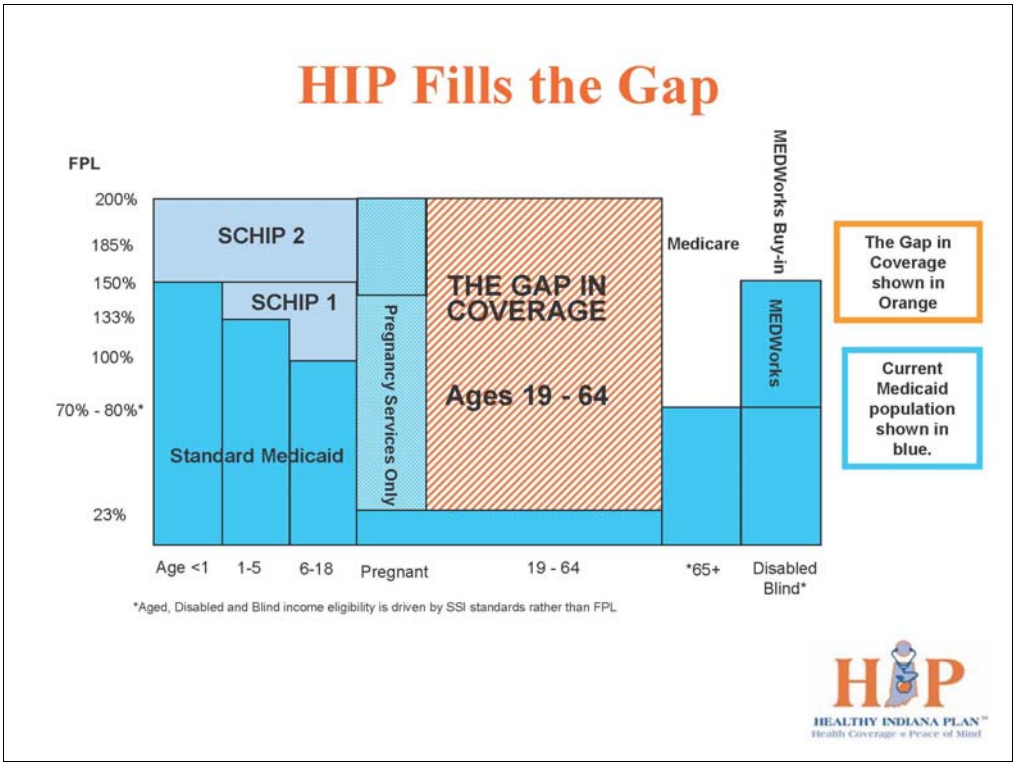
HIP Qualifications

- Age limitations: 19 - 64 years old
- Cannot be disabled

There are also age and income limitations that must be met to qualify for the guaranteed issue portion of the HIP program: an individual must be between 19 and 64 years old.

The philosophy here is a simple one: the legislators did not want to duplicate coverage available through other government programs.

Let's take a look at the "gap" that HIP was meant to cover…



You can see from this chart that Standard Medicaid and SCHIP covers Hoosiers ages 0 – 18 and Hoosier Healthwise (Package B) covers pregnant Hoosiers. In addition, Medicaid covers those 19 – 64 with income levels below 22% of the Federal Poverty Level (FPL), as well as low-income seniors and the disabled.

HIP was designed strictly to cover the gap shown in Orange…Hoosiers between the ages of 19 and 64 with incomes between 22% and 200% of the Federal Poverty Level (FPL).

HIP Qualifications

- Income limitations
  - 22 - 200% of the Federal Poverty Level; Sliding scale for individual contributions (based on % of gross family income)
  - May apply if parent, a caretaker of dependent child, childless
  - Childless adult participants capped at $34,000

As I just mentioned, to qualify for HIP subsidies, an applicant must earn between 22 and 200% of the Federal Poverty Level.

The required contributions for applicants are on a sliding scale and based on gross income. FSSA determines the exact financial contribution once an application is submitted and income is verified. The chosen insurance carrier then notifies the member of their total financial responsibility.

Applications are accepted not just from parents, but also from any caretakers of a dependent child. "**Caretaker relatives" include not just biological parents, but all relatives.**

HIP also covers childless adults. In fact, as of December 2008, about half of the HIP participants were childless adults. This is a high number considering Childless adult participants are capped at $34,000 gross income for the subsidized plan. In March 2009 HIP enrolled the maximum number of childless adults allowed under the plan so childless adults are now being put on a waiting list for coverage.

Income Eligibility

Maximum Income Levels

Number of people in your family	100% FPL	125% FPL	150% FPL	200% FPL
1	$10,210	$12,763	$15,315	$20,420
2	$13,690	$17,113	$20,535	$27,380
3	$17,170	$21,463	$25,755	$34,340
4	$20,650	$25,813	$30,975	$41,300
5	$24,130	$30,163	$36,195	$48,260
6	$27,610	$34,513	$41,415	$55,220
7	$31,090	$38,863	$46,635	$62,180
8	$34,570	$43,213	$51,855	$69,140

HIP
HEALTHY INDIANA PLAN™
Health Coverage + Peace of Mind

Let's take a look at the current Federal Poverty Levels. From this you can see that a family of four with an income of up to $41,300, or 200% of the FPL, would qualify for a HIP subsidy. And a single person with an income of up to $20,420 would also qualify.

HIP Qualifications

- Uninsured with incomes above 200% FPL may buy-in
  - Rates based on age, gender, health status
  - Participant pays full cost

And as of August 2008, individuals with incomes above 200% of the FPL may buy-in to the plan, but rates are based on age, gender, and health status (health underwriting), and the participant pays the full cost of the coverage. In other words, they need to be able to be healthy enough to qualify and have enough income to pay the premium. These are the individuals that ISAHU members can help the most as they have many more options available to them in the private market.

HIP Coverage

- Guaranteed issue for subsidized plans
- Underwritten for over 200% FPL
- Coverage term 12 months; re-certification each year

HIP coverage for applicants with low enough income to qualify for the subsidies is ***guaranteed issue*** – they are offered coverage regardless of their health issues, while applicants whose incomes are above the 200%FPL limit will undergo full underwriting.

And all applicants, whether subsidized or not, need to be recertified for eligibility in the Program every 12 months. If a member is determined to remain eligible for the Program at the end of a coverage term, the member's POWER Account contribution will be recalculated for the new coverage term based on any changes in the member's income. It will may be reduced by the amount of any balance that was rolled-over from the previous term.

HIP Coverage

- Covers essential medical services; *limited benefits with incentives to use health care services efficiently* - inspired by HSA model
  - Preventative services covered at 100% up to $500 annually
  - Services other than preventative subject to $1100 deductible
  - Max $300,000 annually; $1 million lifetime

Like most insurance plans, HIP covers essential medical services. But unlike traditional Medicaid, it has limited benefits with incentives for individuals to use health care services as efficiently as possible. It was inspired by the Health Savings Account (HSA) model. HIP was designed to offer preventative services up to $500 annually covered at 100% so the participant will have no out of pocket costs. However, under the two basic plans currently offered, preventative benefits are unlimited. All other services are covered subject to the $1100 deductible. And the plans have maximum benefits of $300,000 annually and $1 million lifetime.

HIP Coverage

- POWER account
  - Similar to HSA but not tax-deductible ; covers deductible
  - Funded with contributions from both individuals (max 5%) and state
  - Individual contribution determined by number of dependents and income level

Similar to the HDHP (high deductible health plan) and HSA (health saving account), the HIP insurance plan has a side account, called the POWER account which is equal to the deductible. The POWER Account is designed to provide incentives for members to stay healthy, be value- and cost-conscious and to utilize services in a cost-efficient manner as well as to seek price and quality transparency. Members must be aware that prudent management of their health care expenditures can leave them with available funds at the end of the year—and that these funds can be used to lower next year's contribution.

The POWER account is very similar to a Health Savings Account, and the account is funded with contributions from both the individuals and the state. The amount of the individual contribution is determined by the applicant's number of dependents and income level, but the most any participant (who qualifies for the subsidy) will be required to contribute to the POWER account is 5% of their income. For a family of four (two parents and two children), the most they would have to contribute is $105 per month.

The insurance carrier, or Plan, will issue a POWER Account/membership card to each member which will provide them electronic access to their POWER Account funds (debit card). Each member will be responsible for the use of funds in the POWER Account until the deductible is met. However, POWER Account funds can only be used by the member to pay for the Plan's covered services

HIP Coverage

- POWER account
  - Balance rolls over to offset next year contribution if:
    - Participant doesn't use account for medical care, and
    - Meets pre-existing condition requirement, and
    - Meets preventative services goals each year.
  - If not met, only individual contributions roll over.

What's great about the POWER account is that if the participant doesn't have to use the money in the account for medical care; this isn't a "use it or lose" it account. If participants meet the required *pre-existing condition and preventative services goals* each year, the balance in the account will roll-over to offset the contribution for the next year. Since the preventative services are covered at 100%, the participant will have no out of pocket costs for meeting this requirement. And receiving these services can greatly reduce future health care costs

If for any reason the participant does not meet the preventative and/or pre-existing condition requirements, their portion of the POWER account will still roll over, but the state's portion would be lost at the end of the year.

HIP Coverage

- POWER account
  - Financial incentives to adopt healthy behaviors

The whole idea of the POWER Account is to give participants a financial incentive to adopt healthy behaviors that keep them out of the doctor's office.

For example, the ***pre-existing condition requirement*** may include a Personalized Weight Management Program, Tobacco Treatment Program or Health Coach Program. And as a reward for completing a program, the participant may receive a gift card of $50 to $100.

And when a participant does need to seek care, the hope is that they will seek price transparency to make value-conscious decisions because they are spending their own money.

HIP Coverage

- Co-pays - No co-pays except for ER use if not deemed true emergency
  - Parents- $3 to $25 or 20% of total bill; based on income
  - Childless Adults- $25 or 20% of total bill regardless of FPL

With the exception of required POWER Account contributions and co-payments for emergency room services, the program does not allow cost-sharing. Once the deductible is met, covered services are paid at 100%. However, there is one exception in the case of Emergency Room treatment. If treatment is obtained in the emergency room, and the treatment or condition is not determined to be a true emergency, then ER co-pays will apply. For Parents, the co-pay is $3 to $25 or 20% of the total bill, whichever is less (depending upon income level). For Childless Adults, the co-pay is $25 or 20% of total bill, whichever is less, regardless of the income level.

HIP Coverage

- No pregnancy related procedures are covered under HIP
  - If woman becomes pregnant while on HIP
    - Must provide evidence of pregnancy, per current procedures
    - May be switched to Hoosier Healthwise – all pregnancy and other medical services for the woman, pregnancy & otherwise, will be covered by Package B
    - POWER Account balances returned on a prorated basis
  - May re-enroll in HIP following pregnancy

HIP does not cover any pregnancy-related procedures. The reasoning behind this is that pregnancy services are covered by Hoosier Healthwise.

If a woman becomes pregnant while on HIP, she will be switched to Package B of Hoosier Healthwise. The woman must provide evidence of pregnancy, and any POWER Account balances will be returned on a prorated basis. Following the pregnancy, the woman may re-enroll in HIP.

HIP Contributions

- Sliding scale based on gross income:

0-100% FPL: 2%

100%-125% FPL: 3%

125%-150% FPL: 4%

150%-200% FPL: 4.5%- 5%*

** Caretaker relatives/ parental adults in this income bracket contribute 4.5%, and the childless adults contribute 5%.*

Contributions levels for the POWER are on a sliding scale based on gross income:

0-100% FPL: 2%

100%-125% FPL: 3%

125%-150% FPL: 4%

150%-200% FPL: 4.5%- 5%*

** Caretaker relatives/ parental adults in this income bracket contribute 4.5%, and the childless adults contribute 5%.*

HIP Contributions

- Due monthly:
  - Set for each 12 month period
  - Qualifying Event - Individual may request once per year
- Employer may contribute up to 50% of individual's required POWER contribution

HIP Contributions are due monthly, and are set for each 12 month coverage term. The Plan must provide members with an automatic payroll deduction option for making individual contribution payments, in addition to accepting payment by mail. The Plan must also establish a process for employer to forward to the Plan any employee withholding. The Plan must also provide a mechanism that allows members to pay their POWER Account contribution in cash. The Plan may offer additional options for making the required contribution, including automatic withdrawal from the member's checking account, on-line bill pay or other options that make it easy for members to make the required contributions.

Participants may request one change to their POWER Account contribution during the 12 month term of their plan if they have a "qualifying event." Qualifying events include loss of job and reductions in work hours. In addition, if the participant experiences a "family size change" a change can be considered at any time . A "family size change" includes divorce, legal separation, birth or death. The State may consider allowing more than one "qualifying event" a year on a case-by-case basis, if the HIP member experiences a job loss or other change in income that results in undue hardship.

Employers are permitted and encouraged to contribute to member POWER Accounts. An employer's contribution must be used to offset the employee's required contribution and cannot exceed more than 50% of the employee's required contribution. However, the Plan may limit its acceptance of employer contributions to one payment per year.

HIP Contributions

- Lapses - 60 days after due
  - POWER account refund of only 75% of Individual contribution balance
  - Cannot reapply for 12 months

A participant may terminate coverage in the plan at any time and will receive their prorated share of their POWER Account.

If a participant does not make their contribution within 60 days of the due date, coverage will lapse and the POWER account will only refund 75% of the Individual contribution balance, and none of the state's contribution.

The individual may not reapply to HIP for 12 months and will be required to repay any POWER account contributions which are owed.

HIP Coverage

- Switching Plans
  - Individual may switch plans before the1stPOWER Account contribution made
  - After POWER Account/plan benefits begin, applicants can only make plan changes for “poor quality of care.”
  - Must exhaust plan’s grievance procedures first

An individual may switch from one health plan to another anytime before the 1st POWER Account contribution is made. After the first contribution is made, and during the 12 month term, applicants can only make plan changes for “poor quality of care” and they must first exhaust plan’s grievance procedures first.

At the end of each 12-month coverage term, members will have an opportunity to transfer into another plan. The Plan will be required to provide 60 days notice to members about their right to change plans at the end of a coverage term.

HIP Coverage

- Coverage Start Date - 1st day of the following month after POWER Account contribution received

Coverage under the Plan will not begin, and a member's enrollment in the Plan will not be final, until the 1st day of the coverage month after the first POWER Account contribution installment is received, or, if payment is made by check, the check clears.

Example:

- *Client informed of eligibility determination on March 5th*
- *Makes POWER Account contribution on March 15th*
- *Check clears on March 20th*
- *Services begin April 1st*

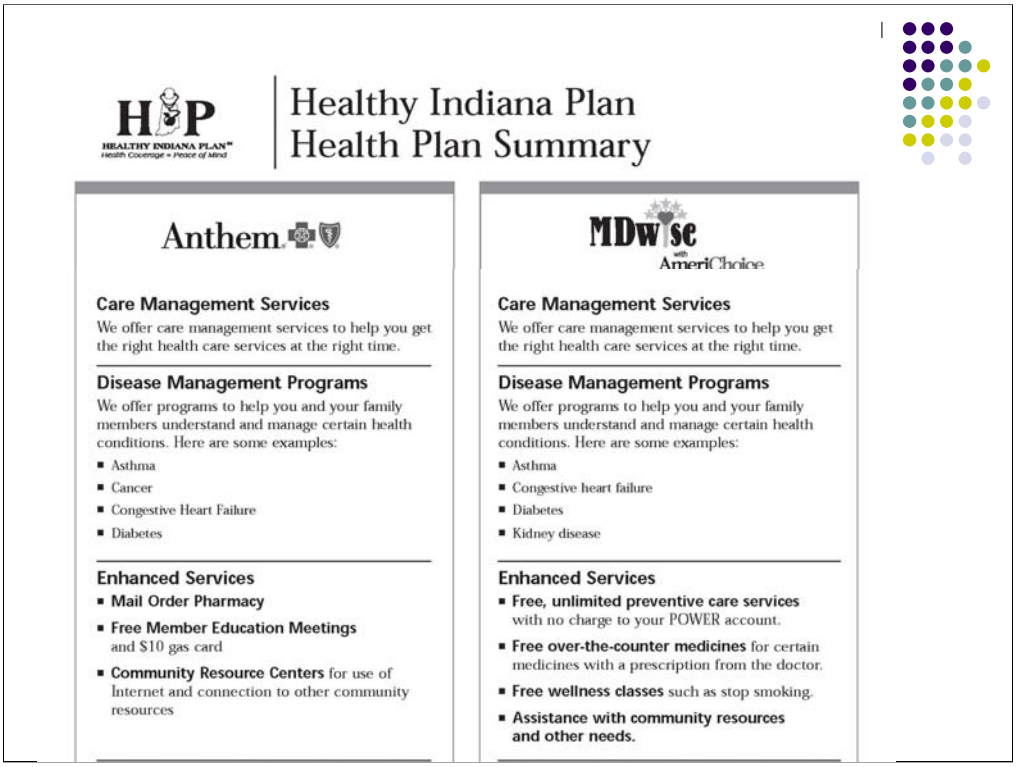
HIP Plans

- Available Plans
  - Anthem
  - MDWise
  - Enhanced Services Plan (ESP)

Currently, there are only two carrier plans approved for HIP: Anthem and MDWise with AmeriChoice. And for applicants with health issues, there is an Enhanced Services Plan. If more than one family member is eligible for the Program, all eligible family members will be required to enroll in the same Plan. The only exception to this rule will occur in families where one of the family members has a high-risk health condition(s) and is referred into the State's Enhanced Services plan.

All plans offer basic benefits, which include, Mental health care services, Inpatient hospital services, Prescription drug coverage, Emergency room services, Physician office services, Diagnostic services, Outpatient services (including therapy services), Comprehensive disease management, Home health services (including case management), Urgent care center services, Family planning services, Hospice services and Substance abuse services.

The Plans limit coverage to services provided by in-network providers only. However, the Plans must authorize and pay for out-of-network care if the Plan is unable to provide necessary covered medical services within 60-miles of the member's residence by the Plan's contracted provider network. For out-of-network services, the Plan must coordinate with the out-of-network provider to ensure that the cost to the member is no greater than it would be if the services were provided in network.



HIP HEALTHY INDIANA PLAN™ Health Coverage + Peace of Mind

Healthy Indiana Plan
Health Plan Summary

Anthem

Care Management Services
We offer care management services to help you get the right health care services at the right time.

Disease Management Programs
We offer programs to help you and your family members understand and manage certain health conditions. Here are some examples:
- Asthma
- Cancer
- Congestive Heart Failure
- Diabetes

Enhanced Services
- **Mail Order Pharmacy**
- **Free Member Education Meetings** and $10 gas card
- **Community Resource Centers** for use of Internet and connection to other community resources

MDwise with AmeriChoice

Care Management Services
We offer care management services to help you get the right health care services at the right time.

Disease Management Programs
We offer programs to help you and your family members understand and manage certain health conditions. Here are some examples:
- Asthma
- Congestive heart failure
- Diabetes
- Kidney disease

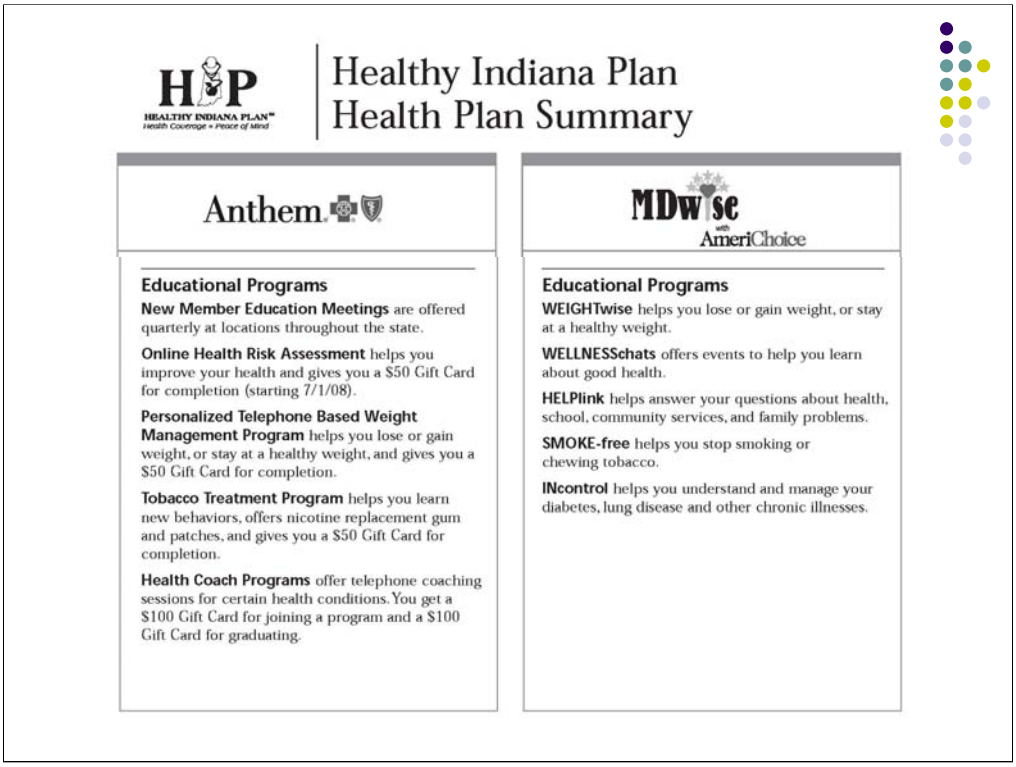
Enhanced Services
- **Free, unlimited preventive care services** with no charge to your POWER account.
- **Free over-the-counter medicines** for certain medicines with a prescription from the doctor.
- **Free wellness classes** such as stop smoking.
- **Assistance with community resources and other needs.**

Due to the Program's POWER Account design, members have an incentive to obtain the best possible pricing. Plans are encouraged to make cost and quality information available to members in order to facilitate more responsible use of health care services and informed decision-making. Plans are also required to devise inventive strategies to make members aware of the cost of health care services, with the goal being that members will act as partners with providers and the Plan to make responsible decisions about appropriate service locations and medically necessary care.

Both Anthem and MDwise plans offer Care & Disease management programs.

Anthem, under its Enhanced Services, offers Mail Order Pharmacy, Free New Member Education Meetings, and Community Resource Centers.

MDwise, under its Enhanced Services, offers Unlimited preventive care benefits with no charges to the POWER Account, Free OTC medication with an Rx from a doctor, Free wellness programs, and Assistance with Community Resources.



In addition, both plans also offer a list of Educational programs…

(Review and compare list with class)

HIP Plans

- Enhanced Services Plan (ESP) - HIP application screened for complex medical conditions
  - High-risk assigned to ESP vendor-Indiana Comprehensive Health Insurance Association (ICHIA)
  - Comprehensive disease management services
  - Access to special network of providers

In addition, HIP offers an Enhanced Services Plan (ESP) for high-risk participants. This plan is offered through the Indiana Comprehensive Health Insurance Association (ICHIA).

HIP applications will be screened for complex medical conditions, but this will have NO bearing on eligibility. Individuals with these conditions may be assigned to the ESP vendor-Indiana Indiana Comprehensive Health Association (ICHIA).

FSSA will contact providers for further information. If condition warrants, the client will remain in ESP or will be transferred to plan of choice

In addition to basic benefits, ESP will provide Comprehensive disease management services and Access to special networks and providers.

HIP

- www.HIP.IN.gov
- 1-(877) GET-HIP 9 (Toll Free)

Additional information may be obtained on HIP's website or through their toll-free number.

HIP

Q & A