



Employer Manual

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Overview

HIP Employer Link is an optional program for individuals eligible for the Healthy Indiana Plan 2.0 (HIP), who have access to employer-sponsored health insurance. HIP Employer Link assists individuals in paying for their health insurance. Individuals must contribute two percent (2%) of their quarterly income towards their employer-sponsored insurance premiums. HIP Employer Link provides individuals with a \$4,000 Personal Wellness and Responsibility (POWER) account to help pay for employer-sponsored insurance premiums and out-of-pocket medical expenses.

The following list describes the basic steps for employers¹ to register and maintain a HIP Employer Link account:

1. Register for a HIP Employer Link account and apply for the program online at <https://secure.in.gov/apps/fssa/hiplink/#/home>
 - Submit employer-sponsored health insurance plan information and upload required documents (e.g., plan benefit summary).
2. Verify HIP Employer Link Employees
 - Confirm employment and insurance enrollment status of employees who apply for HIP Employer Link (including eligible spouse or dependents).
3. Approve Monthly Employee Premium Payment Amounts
 - Confirm employee premium amounts and employment status.
4. Annual Confirmation
 - Confirm profile is up-to-date including changes in health plan benefits and premium rates.

Employer Eligibility

General Information

The following criteria have been established to help employers identify whether they are eligible to participate in HIP Employer Link. At minimum, employers should:

- Have employees who are legal residents of the state of Indiana.
- Have a federal employment identification number (FEIN).
- Contribute at least fifty percent (50%) of the premium cost.

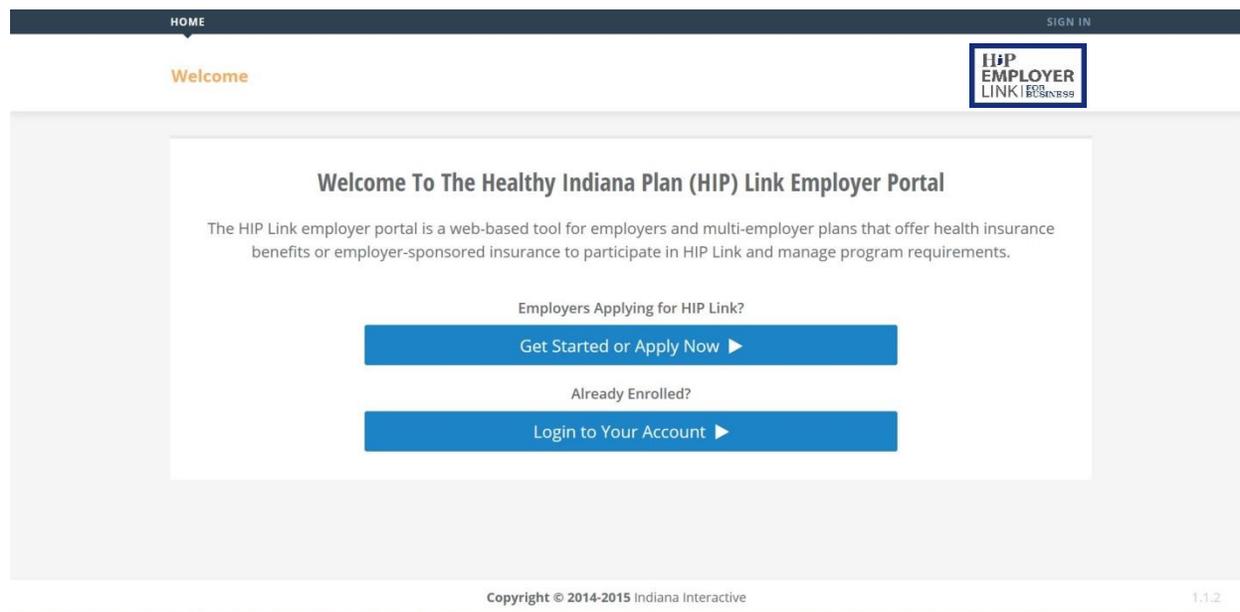
The employer's fifty percent (50%) premium contribution must be in at least the employee only or single coverage type offered.

The employer will confirm the above information in Session I of the application.

¹ Multi-employer plans use the same steps as employers to apply as a HIP Employer Link participant and must maintain program requirements.

Eligibility Verification

Upon receipt of the first session of the employer's application through the Employer Portal, FSSA will verify the employer's eligibility to participate in HIP Employer Link. FSSA will notify employers of the next steps to complete the enrollment process to become an eligible employer.



Employers will receive the below email after completing Session I which describes the remaining application requirements.

Dear Employer,

Thank you for completing the first part of the HIP Employer Link application. The following link <https://secure.in.gov/apps/fssa/hiplink/#/home> will return you to the employer portal to complete the second part of the application. For the remaining application, you will need to provide the information below for each health plan you offer.

1. Select the type of plan offered to employees.

Type of Plan	# Full time Employees	Additional Information
Fully Insured	2-50 Small Employer; 51+ Large Employer	<ul style="list-style-type: none"> • Small Group or Large Group Health Plans purchased through an agent, broker or insurance company <ul style="list-style-type: none"> ○ Other names: nongrandfathered plan, grandfathered plan OR transitional plan ○ Small Group- May offer a qualified health plan (QHP); QHP plan may have been purchased on

		the Small Business Health Options Program (SHOP) online marketplace
Self-Funded Plan	Varies	<ul style="list-style-type: none"> • Funded by employer <ul style="list-style-type: none"> ○ Employer funds employee health expenses • Plan design may be unique to employer • Plan has a third party administrator

2. Attest that each offered plan meets all 3 components of HIP Employer Link benefit requirements.

1	<p>Indiana Essential Health Benefits Options</p> <ul style="list-style-type: none"> • Anthem Blue Access PPO- Indiana’s Essential Health Benefits Plan available at http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/indiana-ehb-benchmark-plan.pdf; • United Healthcare POS; or • Advantage HMO 	OR	<p>Minimum Value plus coverage of specified benefit categories</p> <ul style="list-style-type: none"> • Minimum value calculator available at http://www.cms.gov/site-search/search-results.html?q=minimum%20value%20calculator. • Benefit coverage for specific benefit categories: 1) Ambulatory patient services, 2) Emergency services, 3) Hospitalization, 4) Maternity and newborn care, 5) Mental health and substance use disorder services, 6) Prescription drugs, 7) Rehabilitative and habilitative services and devices, 8) Laboratory services 9) Preventive and wellness services and 10) Pediatric services
2	<p>Mental Health Parity and Addiction Equity Act (MHPAEA)</p> <p>Provides mental health and substance use disorder benefits at parity with medical benefits available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.</p>		
3	<p>Abortion</p> <p>Does not cover abortion for which federal funding is prohibited; reference http://www.cms.gov/site-search/search-results.html?q=abortion%20for%20which%20federal%20funding%20is%20prohibited. Does not cover elective abortions; reference https://iga.in.gov/legislative/laws/2014/ic/titles/027/articles/008/chapters/13.4/.</p>		

3. Provide information about insurance coverage for health, dental and/or vision, if offered.

- Who is eligible: Employees, spouses and/or dependents;
- Dates for open enrollment period;
- Dates for current benefit period;
- Length of the waiting period after a new hire;
- If a Health Savings Account (HSA) or Health Reimbursement Account (HRA) is offered;
- If dental and/or vision coverage is offered; and
- Health Insurance Plan Name, Certificate ID, and Group ID.

4. Upload information for each health, dental and/or vision plan offered.

- Premium rates² for each plan;
- Summary of Benefits and Coverage, Schedule of Benefits, Certificate of Coverage, Prescription Drug Formulary or Benefit Summaries, if applicable; and

² Employers offering an Early Retiree Program (ERP) must include premium rates if different from other employees.

- Employer contributions for HRA or contribution arrangement.

- 5. Designate a HIP Employer Link Administrator.** The administrator will respond to data requests from the state, such as confirming employment or updating employer profile as needed. Additional administrators may be added.

After you submit the second part of the application, the information is reviewed. If the application is approved, you will receive a HIP Employer Link Employer ID. Please contact 1-800-457-4584 or HIPEmployerLink@fssa.in.gov if you have questions.

Employer Application

HIP Employer Link Portal

Employers should apply for enrollment into HIP Employer Link using the online portal at <https://secure.in.gov/apps/fssa/hiplink/#/home>.

The application contains questions and fields designed to access the identity of the employer, determine the type of employer health plan and benefits offered and determine if the employer's health plan is affordable. The [Employer Application Process](#) is available in the appendix to assist the employer with completing the application.

Employers will also use the portal to manage their employees enrolled in the program. In particular, employers will verify employees' employment status and employer health plan participation.

Employer Identification

Employer Identification Number

Each employer who is approved to participate in HIP Employer Link will receive a unique nine-digit identification number, such as 201501004, which can be shared with employees. Employers will receive an email containing their ID number after their application is approved. The HIP Employer Link ID number can be provided to employees who want to enroll in the program. It is used by the state to help to verify that the applicant's employer is approved for HIP Employer Link.

Eligibility by Employer Type

Multi-Employer Health Plans

Multi-employer health plans, including unions, who provide insurance for their union members may qualify for HIP Employer Link. Multi-employer health plans should apply for HIP Employer Link using the portal, located at <https://secure.in.gov/apps/fssa/hiplink/#/home>. These health plans will be asked to provide much of the same information as employers.

Fully Insured Employers

Small Employers

Employer Eligibility

Small Businesses with a Federal Employer Identification Number (FEIN) that employ 50 or fewer full-time employees and have at least one employee that is an Indiana resident may qualify for HIP Employer Link. For employees to participate the employer should offer a HIP Employer Link eligible health plan and pay at least 50 percent of the premium cost of the employer-sponsored health insurance.

Small Employer Health Plan Eligibility

Fully insured health plans offered by small business owners are reviewed and regulated by the Indiana Department of Insurance (IDOI). These plans may need to be verified by the state as meeting the benefit and [affordability requirements](#). The following are the names and descriptions of the different types of plans that are offered to small business owners:

- Small Group Health Plan Non-grandfathered Plan or Qualified Health Plan (QHP) – These plans may have been purchased on the Small Business Health Options Program (SHOP) online marketplace or purchased as a small group health plan or a QHP independent of the SHOP and meet the Affordable Care Act (ACA) requirements. These plans meet the benefit requirements to be HIP Employer Link eligible, but would need to be verified as affordable.
- Small Group Health Plan Grandfathered or Transitional Plans – Employers with grandfathered plans have had their plan since March 23, 2010, or prior. Employers with transitional plans have not changed their plan since 2013. In general, these plans have not had changes to benefits or the employee’s cost since plan inception. These plans are not guaranteed to meet the benefit requirements for HIP Employer Link and may offer benefits on a rider. These plans will need to be verified by the state as meeting the benefit and affordability requirements.
- Non-Indiana Small Group Plan – This plan is for a business located outside of Indiana in which the plan offered to employers that reside in Indiana is not certified in Indiana. This could include Small Group, Large Group and Self-funded plans. These plans are not guaranteed to meet the benefit requirements for HIP Employer Link. These plans would need to be verified by the state as meeting the benefit and affordability requirements.

Large Employers

Employer Eligibility

Large businesses with a Federal Employer Identification Number (FEIN) that employ more than 51 or more full-time employees and have at least one employee that is an Indiana resident may

qualify for HIP Employer Link. For employees to participate, the employer should offer a HIP Employer Link eligible health plan and pay at least 50 percent of the premium cost of the employer-sponsored health insurance.

Large Employer Health Plan Eligibility

Fully insured health plans offered by large business owners are reviewed and regulated by the IDOI. These plans may need to be verified by the state as meeting the benefit and affordability requirements. The following are the names and descriptions of the different types of plans that are offered to large business owners:

- Large Group Plan Non-grandfathered – These plans meet most of the requirements to be HIP Employer Link eligible, but would need to be verified by the state as meeting the benefits and affordability requirements. These plans may also meet the Affordable Care Act (ACA) requirements.
- Large Group Plan Grandfathered or Transitional Plans – Employers with grandfathered plans have had their plan since March 23, 2010, or prior. Employers with transitional plans have not changed their plan since 2013. In general, these plans have not had changes to benefits or the employee’s cost since plan inception. These plans are not guaranteed to meet the benefit requirements for HIP Employer Link and may offer benefits on a rider. These plans would need to be verified by the state as meeting the benefit and affordability requirements.
- Non-Indiana Large Group Plan – This plan is for a business located outside of Indiana in which the plan offered to employers that reside in Indiana is not certified in Indiana. This could include Small Group, Large Group and Self-funded plans. These plans are not guaranteed to meet the benefit requirements for HIP Employer Link. These plans would need to be verified by the state as meeting the benefit and affordability requirements.

Self-Insured/Self-Funded Employers

Employer Eligibility

Self-insured businesses with a Federal Employer Identification Number (FEIN) that have at least one employee who is a resident of Indiana may qualify for HIP Employer Link. For employees to participate, the employer must offer a HIP Employer Link eligible health plan and pay at least fifty percent (50%) of the premium cost of the employer-sponsored health insurance.

Self-Funded Employer Health Plan Eligibility

A self-funded plan is solely funded by the employer in which the plan design is unique to the employer. Instead of paying a premium to an insurer, the employer funds the health expenses of the employees. Insurers may act as administrators of the plan. These plans would need to be verified by the state as meeting the benefit and affordability requirements. The other type of self-funded plan in the program may be the following:

- Non-Indiana Self-Funded Group Plan – This plan is for a business located outside of Indiana in which the plan offered to employers that reside in Indiana is not certified in Indiana. This could include Small Group, Large Group and Self-funded plans. These plans are not guaranteed to meet the benefit requirements for HIP Employer Link. These plans would need to be verified by the state as meeting the benefit and affordability requirements.

Health Plan Eligibility

As part of the application process, employers will be required to provide information on the benefits offered and cost sharing required in their health insurance plan. This includes uploading the summary of benefits and coverage document, schedule of benefits, certificate of coverage or summary plan description, prescription drug formulary, premium rates for the employer and employees and Health Reimbursement Account (HRA) amounts. (See the [Employer Application Reference](#) in the appendix for a description of these documents and other application tips.) The state will review the plan to determine if HIP Employer Link eligibility criteria is met. Eligible plans will meet the following benefit and affordability requirements.

Benefit Requirements

The following criteria have been established to help employers identify whether their employer-sponsored health plans are eligible for HIP Employer Link.

1) The health plan should meet one of the following state’s essential health benefit options:

- Anthem Blue Access PPO available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/indiana-ehb-benchmark-plan.pdf>;
- United Healthcare POS; or
- Advantage HMO; OR
- Meet the federal requirements for minimum value described at: <http://www.cms.gov/site-search/search-results.html?q=minimum%20value%20calculator> AND offer benefits in all of the following essential health benefit categories:
 - Ambulatory patient services,
 - Emergency services,
 - Hospitalization,
 - Maternity and newborn care,
 - Mental health and substance use disorder services,
 - Prescription drugs,
 - Rehabilitative and habilitative services and devices,
 - Laboratory services,
 - Preventive and wellness services and Pediatric services.

2) The health plan should not cover abortion services for which federal funding is prohibited:

- **Federal law:** Prohibits federal funds from being used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). Federal abortion law displayed at: <http://www.cms.gov/site-search/search-results.html?q=abortion%20for%20which%20federal%20funding%20is%20prohibited>.
 - **State law:** Prohibits health plans from providing coverage for abortion (except in cases of rape or incest, or when the life of the woman would be endangered). State abortion law displayed at: <https://iga.in.gov/legislative/laws/2014/ic/titles/027/articles/008/chapters/13.4/>.
- 3) The health plan should comply with the parity protections for mental health and substance use disorder services. Information concerning the parity protections for mental health and substance use disorder services are displayed at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

Affordability Requirements

In order to be eligible as a HIP Employer Link Plan, the \$4,000 HIP Employer Link POWER account and the individual's contribution to their premiums must be sufficient to cover the premium and expected out-of-pocket costs to be affordable under the state's Medicaid requirements. Employers will submit documentation to support the state's plan affordability review, including premium rates, summaries of benefit and coverage, and amounts made available to fund out-of-pocket expenses through HRA accounts on behalf of individuals, if offered.

To determine whether an employer's plan is affordable, the state will use the employer's premium rates and summary of benefits and coverage to determine the potential costs of a plan. These costs will be compared to the available funds in the \$4,000 POWER account and expected claims for the average HIP Employer Link member with an annual income of \$16,000. The employee tiers or coverage types offered by the employer will also be considered when determining if a plan is affordable. For example, if an employer offers employee only, spouse and dependent coverage, the employee and dependent coverage option may be determined unaffordable, but the employee only coverage may be affordable. The employer will receive the information regarding which of the employer's plans and coverage types were determined affordable.

Health Insurance Plans

Insurance companies that offer health insurance coverage can complete the online form at <https://secure.in.gov/apps/fssa/insurers-application-form/> to become eligible HIP Employer Link plans. The health plans will be reviewed to ensure benefits only comply with program benefit requirements. Some small group plans that are non-grandfathered or qualified health plans may comply with the HIP Employer Link benefit requirements and are not required to complete the online application. A list of health insurance companies that may offer small group plans that comply with the benefit requirements is available at <http://www.in.gov/fssa/hip/2502.htm>.

Other Requirements

- **HSAs:** Health savings account (HSA) contributions do not represent tax-exempt income for employees enrolled in HIP Employer Link. If an employer offers an HSA, the employer and employee need to discontinue contributions for the HIP Employer Link employees to avoid potential tax liability. HSA existing balances may be used for qualified health expenses when enrolled in HIP Employer Link.
- **HRAs:** Employers who have health reimbursement arrangements (HRAs) are eligible to participate in HIP Employer Link, and employees who are enrolled in HIP Employer Link can use their HRAs according to the guidelines established by their employer. HRA contributions will be counted towards determining health plan affordability, and the dollar value or amount of the HRA contribution should be included in the employer's application.

Employers may be contacted to determine how their HRA payments are administered. For example, some employers may pay for out-of-pocket expense upfront or first, or require the employee to pay a certain amount, then the HRA or employer will pay after the employee or second.

Health Plan Eligibility Verification

Plan affordability is verified from the premium rates and benefit summaries the employer uploads for review as part of the employer application. Once the employer completes the application process and submits the plan information, the state will review the plan to verify that it meets the program's eligibility criteria. If the state has questions, the state will follow-up with the employer. Employers can expect that the state will make a decision on their plans within thirty (30) calendar days of receiving the complete application including the uploaded documents.

Employee Eligibility

Employees must be eligible for HIP, and have access to their employer-sponsored insurance plan to participate in HIP Employer Link.

Employers should refer employees who already have HIP but would like to enroll in HIP Employer Link to contact the Division of Family Resources (DFR) call center at 1-800-403-0864 and request to be enrolled in HIP Employer Link. Employees not currently enrolled in HIP should apply for Indiana Health Coverage Programs online at <https://www.ifcem.com/CitizenPortal/application.do>, at their local DFR office, or through contacting the call center at 1-800-403-0834.

The Family and Social Services Administration (FSSA) also provides general information about program eligibility and application on the FSSA website at HIPEmployerLink.IN.gov.

Employee Enrollment

Employees who are approved for HIP by DFR will be referred to the employer listed on their application for verification. Employers have authority to confirm that the employee is both employed by the employer and eligible to participate in the employer's eligible HIP Employer Link insurance plan, prior to

the employee enrolling into HIP Employer Link. Employers can verify the employee's status using the online portal.

Being determined eligible for HIP Employer Link (a Medicaid-sponsored program) qualifies as a special enrollment period for health insurance under Federal Law³. The special enrollment may be up to 60 days for and will begin when the employer verifies the employee is eligible for HIP Employer Link. Additionally, the federal provision, enables HIP Employer Link employees to be added to their employer's health insurance plan at any time throughout the year, even outside of the open enrollment period. After eligibility is determined, HIP Employer Link coverage will always begin on the first day of the month. Once an individual is verified as eligible, HIP Employer Link will be available to the individual beginning the first day of the month in which they are also enrolled in employer-sponsored insurance. This could be as soon as the month that the individual applied for the program. Employees subject to waiting periods may enroll in HIP while waiting to be eligible to start HIP Employer Link coverage. The employer's benefit period remains the same.

Verification of Employee Eligibility

All HIP Employer Link organizations will communicate employee information using the online portal. The employer will receive an email after an employee selects HIP Employer Link on the state's eligibility application and individual is determined eligible. The employer will be asked to verify the following initial employee data within 5 days of receiving the email to ensure there is a proper match for employment and to confirm coverage information. The employer is only to complete the information available. For example, if a member is employed, but not currently enrolled in the employer's health plan, the data regarding coverage type or other related health insurance information cannot be completed. The employer will complete the information after the group health coverage application is completed by the employee.

The following provides a portal view and examples of the information sent to the employer to verify the employee. The employer counseling team (ECT) will contact the employer to confirm enrollment of a spouse or dependent.

³ The following links provide reference to Federal law: <http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf> and <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=23521&AgencyId=8&DocumentType=3>.

HOME EMPLOYERS SIGN OUT

Employee Verification

Current Employee: JOHN SMITH
Employer: Employer, LLC

Employee Information

Please confirm that the following information for JOHN SMITH is correct:

First Name	Last Name	SSN	Birth Date
John	Smith	*****0000	Jan 01, 1980

Yes, the information is correct
 No, the information is incorrect

Employee Eligibility

In order for JOHN SMITH to be eligible for HIPLink, all of the following criteria must be met:

- JOHN SMITH must be employed by Employer, LLC
- JOHN SMITH must be enrolled in Employer, LLC's employer sponsored health benefits, or will be within 90 days.

JOHN SMITH meets all criteria
 JOHN SMITH is not eligible

Action

Save Progress
Verify

Form Tips

All fields are required unless otherwise denoted.

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- Verify the name, last four numbers of SSN and DOB is correct.
- Is [employee name] currently employed by [employer]? ___ Yes ___ No
- Is [employee name] currently enrolled in health benefits or will be in the future?
___ Yes ___ No
- Select tier or coverage type for [employee name].
- If coverage for eligible spouse or dependent is selected, employer will verify name, last four numbers of SSN and DOB for each member.
- Select the enrolled health plan for the employee and provide the employee premium contribution.
- Select the coverage effective begin and end dates (xx/xx/xxxx – xx/xx/xxxx) for [employee name] for the current benefit period. If the coverage type includes spouse or dependent coverage, add the coverage effective dates for each, if different from the employee.
- Enter Health Reimbursement Account (HRA) annual contribution amount, if offered, for [employee name] during the current benefit period.

Management of Employee Eligibility

HIP Employer Link employers will receive a request to complete the following data checks on a monthly basis. An annual confirmation is also requested.

Employee Monthly Data Confirmation

The following provides a portal view and examples of the information sent to the employer to verify the employee on a monthly basis.

The screenshot shows the 'Reverification' portal for an employer. At the top, there are navigation links for 'HOME', 'EMPLOYERS', and 'SIGN OUT'. The employer's name is 'Employer, LLC' and the status is 'Approved'. Below this, there is a search filter for 'Filter Results' and a list of employees. Two employees are listed: JOHN SMITH and TOM SMITH. Each employee entry includes a checkbox, a 'Show Details' button, and a table of information: SSN, Birth Date, Coverage, Dental, Medical, Vision, Total Premium, Spouse, and Dependents.

Employee Name	SSN	Birth Date	Coverage	Dental	Medical	Vision	Total Premium	Spouse	Dependents
JOHN SMITH	*****1234	Jan 1, 1980	Insurance Plan	\$500.00	\$8,000.00	Not Covered	\$8,500.00	Covered	Covered
TOM SMITH	*****4321	Dec 31, 1970	Insurance Plan Bronze	\$60.00	\$1,200.00	\$36.00	\$1,296.00	Not Covered	Not Covered

Annual Confirmation

Note: The state will send the employer a request to begin the annual confirmation at least 60 days prior to the start of their open enrollment period.

- a) Confirm if application or profile information is up to date for the employer prior to or after annual open enrollment period.
- b) Provide changes to benefits or premium rates that may impact the current or new benefit period.
 - Plan amendments for benefits, premiums or other coverage changes that may impact employee's health coverage in the current benefit period need to be submitted to the state within 13 days following the change.
 - Plan amendments for benefits, premiums or other coverage changes that may impact employee's health coverage or new plan added for the subsequent or new benefit period need to be submitted to the state at least 30 days prior to the employer open enrollment period. Changes to benefits for the subsequent plan year must be submitted by December 1 for benefit periods based on the calendar year.
- c) Confirm the employee, spouse and dependent information with any updated plan selection information as provided for the [Employee Monthly Data Confirmation](#).

The state will need to review for benefits and affordability requirements if health plan design changed or new plan offered. Information regarding plan changes may be communicated in the portal or sent to the employer counseling team at HIPEmployerLink@fssa.in.gov.

Additionally, the portal will allow employers to update their profile, such as a business address change any time throughout the year.

Employee Premium Contribution

Employees are required to contribute two percent (2%) of their income towards their employer-sponsored insurance premiums in order to participate in HIP Employer Link. Dependents up to age 26 that meet the eligibility requirements may participate in the program if family coverage is offered by the employer. The two percent (2%) contribution for enrolled eligible spouses is based on household income and shared between spouses and dependents that reside in the household. Dependents added to employer-sponsored insurance that do not reside in the household per the modified adjusted gross income rules will have a separate two percent (2%) of income contribution.

Employers will follow the standard procedure of deducting premium contributions directly from the employee wages. The state will reimburse the employee on a monthly basis the difference between their two percent (2%) of their quarterly income and the employee premium amount for the employer-sponsored insurance. The member's total costs for premiums and cost sharing for covered health care services may not exceed five percent (5%) of their household income on a quarterly basis.

Reimbursement of employee premium contribution payments will be conducted as follows:

- The state will reimburse employees in advance of employer payroll deductions.
 - **Employers should confirm employee premium amounts by the third Tuesday of each month. See [HIP Employer Link Premium Payment Schedules](#) in the appendix. Employees will receive payment approximately two weeks after their employer confirms their premium amount.**
- The state will send employee reimbursements on a monthly basis. Reimbursement payments will equal 1/12th of employee annual premium contributions.
- Reimbursements will be sent to employees through mail.
- HIP Employer Link members that receive reimbursement when they are not eligible for the employer's group health plan will be subject to benefit recovery.

HIP Employer Link Member Benefits

HIP Employer Link provides coverage for the out-of-pocket costs associated with the employer-sponsored health insurance plan, including copayments, coinsurance and deductibles. HIP Employer Link also includes limited additional services including 72-hour emergency supply of medications, family planning services, and services provided in federally qualified health centers or rural health centers. Certain members that meet specific criteria may also qualify for non-emergency transportation to medical appointments. Also, members that are 19 or 20 years of age may receive Early and Periodic Screening, Diagnosis and Treatment services not covered by the employer health plan. Employees with questions on benefits may call 1-877-GET-HIP-9.

HIP Employer Link Personal Wellness and Responsibility (POWER) Account

Members will each have a \$4,000 HIP Employer Link POWER account funded by the state that will be used to reimburse the member for their premium payments for employer-sponsored insurance and pay

providers and pharmacies for out-of-pocket expenses, such as copayments, coinsurance and deductibles. The \$4,000 account limit is allocated on an annual basis or when coverage for health benefits begins. HIP Employer Link members cannot withdraw funds from the POWER account. If funds in the POWER account have been used, members are responsible for paying up to five percent (5%) of their household income for services received. The amount the member pays will be based on Medicaid allowable cost sharing limits. This amount will be deducted from the premium reimbursement sent to the member on a monthly basis.

If more than one household is enrolled on the same employer policy, for example a parent and their 24 year old child living separately, then the five percent (5%) limit will take into account the total income of all members. Once the HIP Employer Link POWER account funds are depleted and the member has met their five percent (5%) of income cost limit, the state will determine if it is cost effective for that member to remain enrolled in HIP Employer Link and medical expenses will be covered up to the health plans' maximum out-of-pocket. If it is not cost effective, the member will no longer be eligible for HIP Employer Link and will be transferred to the standard HIP program.

All HIP Employer Link providers must be enrolled with the Indiana Health Coverage Programs (IHCP) and be an in network provider under the employer's plan for the POWER account to pay the provider directly. IHCP providers can be found at <http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx>. HIP Employer Link will cover services that are out of network on the employer's plan for the limited additional services as described above under [HIP Employer Link Member Benefits](#). Members that receive services from providers that are not enrolled in the IHCP, but are in network under the employer's plan may receive reimbursement for the services received. The member will need to print and complete the [HIP Employer Link Out-of-Pocket Reimbursement Form](#). The form includes the following information: (1) Member's name and RID; (2) HIP Employer Link ID; (3) Provider's invoice; (4) Receipt of payment; and (5) Explanation of benefits (EOB) from your primary insurance provider. Members can email or mail the form to FSSA at HIP2.0@fssa.in.gov or to P.O. Box 1995, Indianapolis, IN 46206-1995. The reimbursement will be sent to the member as soon as it is processed.

HIP Employer Link ID Card

Each employee and eligible spouse or dependent will receive a HIP Employer Link card. The card will provide the information needed for health providers and pharmacies to submit the claims data to the state to process their out-of-pocket medical expenses. The card does not provide direct access to funds in the Link account and will function as supplemental coverage.



Disenrollment

Employer Disenrollment

To be a HIP Employer Link organization, the employer must maintain the program requirements as described in this manual. Failure to meet the program requirements, may result in disenrollment from the program and end HIP Employer Link benefits for participating employees. If an employer chooses to disenroll or withdraw from the program, the employer must notify the state promptly to ensure timely transition of members/employees to other coverage options.

Employee Disenrollment

These events must be allowed for an employee to disenroll from the employer health plan, if the employee chooses to do so:

- **Pregnancy:** Individuals who become pregnant have the option to disenroll from HIP Employer Link and transfer to another HIP plan. Pregnant individuals who are enrolled in HIP are exempt from all cost sharing, including making required monthly POWER account contributions or copayments, up to 60 days post-partum.
- **Medically frail:** Medically frail is a complex medical condition that is federally designated and includes disabling mental disorders; chronic substance use disorders; serious medical condition; physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living (ADLs); or disability determination from the Social Security Administration (SSA). Individuals who become medically frail will be transferred to the standard HIP program.
- **Low-income parent or caretaker or Transitional Medical Assistance (TMA):** Low-income parent or caretaker or TMA member may transfer out of HIP Employer Link to HIP at any time. Members in these categories are also eligible for non-emergency transportation in HIP Employer Link. Members may contact the Division of Family Resources at 1-800-403-0864 for questions about eligibility.
- **Health insurance coverage is not cost-effective:** The state will review whether the Link coverage remains cost-effective when the HIP Employer Link account is at risk of being depleted. If their coverage is cost effective, the member will remain enrolled in the program. If the coverage is not cost-effective, then the employee will no longer be eligible for HIP Employer Link and would be enrolled in the standard HIP program offered by the State of Indiana. Disenrollment from HIP Employer Link does not require the employee to disenroll from their employer-sponsored insurance, however, HIP Employer Link will no longer be available to help pay for premiums and out-of-pocket costs.
- **Employer's health insurance plan fails to meet program requirements:** Individuals will be disenrolled from HIP Employer Link and will be transferred to another HIP plan if their employer's health insurance plan fails to meet minimum requirements.
- **Eligible individual, spouse or dependent becomes ineligible for group health coverage from the employer:** If an employee or their eligible spouse or dependent becomes ineligible for group health coverage from the employer, then the employee or dependents may transfer to another

HIP plan if the loss of spouse or dependent makes their coverage unaffordable; or ineligible for the employee.

Employees may also elect to disenroll from HIP Employer Link during the employer's open enrollment period or their annual redetermination. Employees under FMLA who may no longer be receiving monthly payroll will be reviewed on a case by case basis for disenrolling from HIP Employer Link.

Employees who qualify and choose to transfer to HIP will be disenrolled from HIP Employer Link. While such member is not required to also disenroll from their employer-sponsored health insurance, by becoming eligible for a new Medicaid benefit package, the member is automatically eligible for a special disenrollment period due to their Medicaid eligibility. This provides the individual the opportunity to either disenroll from their employer-sponsored health insurance or to otherwise make changes to their plan selections (i.e. covered beneficiaries). Employees eligible for a special disenrollment period must notify their employer in accordance with the employer's standard policy, procedures, and timeframes required for such special disenrollment periods.

A member who voluntarily withdraws from HIP Employer Link during the employer plan's benefit period or loses access to the employer's coverage will not be allowed to reenroll in HIP Employer Link unless it is during an employer's special enrollment or open enrollment period. An individual shall have only one opportunity to enroll in HIP Employer Link during an employer's special enrollment period every two years. Employers should direct employees that want to disenroll from HIP Employer Link to contact the Division of Family Resources at 1-800-403-0864 and report a change.

Notification of Employee Removal from Employer Health Plans

Employees who are no longer enrolled in the employer's health plan are not eligible for the monthly premium reimbursement and may be subject to benefit recovery. An employer may not be able to continue as a HIP Employer Link employer if they fail to complete the [monthly confirmation request](#) which verifies active participants and health benefits coverage dates.

Benefit Recovery

Employees subject to benefit recovery will be billed by the state for months where premiums were paid, but the individual was not eligible for HIP Employer Link or enrolled in the employer-sponsored insurance. Recoupment of premiums paid in error may also be deducted from individual state tax returns.

Employee Questions

Employers should direct employee questions concerning HIP Employer Link to 1-877-GET-HIP-9 or HIP2.0@fssa.in.gov.

Appeals

Employers may appeal the program eligibility decision as an applicant or change in eligibility by contacting the HIP Employer Link team at 1-800-457-4584 or HIPEmployerLINK@fssa.in.gov. If an

appealable action is based on a change in the employer's eligibility status, the member will transfer to HIP coverage, and HIP Employer Link benefits will end during the appeal process.

Employee appeals for benefits from the employer-sponsored health coverage will be handled by the primary insurance company. The employee may request a state fair hearing within thirty-three (33) days of the insurance company's final decision on appeal if the individual does not agree with the decision of the health insurance company after the individual exhausted the insurance company's grievance and appeal process. Appeals related to out-of-pocket medical expenses as funded from the POWER account will be handled by the state. If an appealable action is based on a change in the employee's eligibility status, the member will remain in the HIP Employer Link benefits during the appeal process.

Note: The employee may contact the state to consider coverage for denied services. The state will review the service as compared to the state's essential health benefits options.

Employer Rights and Responsibilities

To maintain status as an approved employer, employers are responsible for updating the state of any changes to the health insurance benefits offered to employees including but not limited to changes that drop the employer contribution below 50 percent of the premium cost, changes to benefits, dependent coverage or employee premium rates. Employers are also responsible for informing the state during the monthly confirmation when enrolled employees are no longer eligible for the employer's health coverage to minimize benefit recovery actions for HIP Employer Link members.

Employers will be informed by the state 30 days in advance of changes to the HIP Employer Link program that impact employers or their employees including changes to plan or employer eligibility requirements. Employers have the right to appeal state decisions that disqualify them from eligibility for HIP Employer Link.

Appendix

HIP Employer Link Employer Application Process

STEP 1: CONFIRM HIP EMPLOYER LINK ELIGIBILITY – SESSION I

The Indiana Family and Social Services Administration (FSSA) has established eligibility guidelines to assist employers and multi-employer plans in determining whether they qualify as a HIP Employer Link Employer. At minimum, employers or multi-employer plans should:

- Have employees or covered members who are legal residents of the state of Indiana.
- Have a federal employment identification number (FEIN).
- Contribute at least fifty percent (50%) of the cost of employee or member health insurance premiums. The employer must contribute fifty percent (50%) in at least the employee only or single coverage type offered.

Employers or multi-employer plans will be asked to confirm the three eligibility statements.

Due to federal and state law, the HIP Employer Link program may not include health plans that cover elective abortions.

STEP 2: COMPLETE EMPLOYER INFORMATION – SESSION I

Employers or multi-employer plans can apply using the online portal available at <https://secure.in.gov/apps/fssa/hiplink/#/home>.

The remaining information to complete for Session I includes the following:

- Business Legal Name or Multi-Employer Plan Name
 - Business Type
 - FEIN
 - Tax Exempt Number for non-for-profit organization, if applicable
 - Doing Business As (DBA) or Other Name if the business operates under a different name than the legal business or multi-employer plan name
 - Primary Contact Information
 - Name (first, last)
 - Title
 - Email
 - Phone/Fax number
- Legal Business/Mailing Address

STEP 3: SUBMIT SESSION I

Applicant is to input their FEIN to confirm the information in Session I is accurate; create a user id and password; and then submit Session I. The applicant will receive an email with information to complete Session II.

STEP 4: COMPLETE HIP EMPLOYER LINK EMPLOYER APPLICATION – SESSION II

Applicants can complete Session II immediately after completing the first session of the application.

HIP Employer Link Administrators

- Primary contact is also the initial HIP Employer Link Administrator. Additional administrators can be added during or after the application process is complete. The administrator will facilitate the requirements of the portal and respond to state data requests. Employer or multi-employer plan business address (city, state, zip)

Step 4a: Health Plan Information

Applicants will be asked to provide the following information about their health plan:

Note: Applicant may provide information for more than one plan.

- Plan Name
- Certificate ID- The number located on the front of the certificate of coverage or summary plan description.
- Group ID- The number displayed on the health insurance card.
- Type of health plan offered by the applicant, such as [Fully Insured](#) or [Self-Funded](#) as described above in this manual.

Program Standards- Applicants are to attest to complying with the below health plan requirements.

- 1) Meet one of the following state's essential health benefit options:
 - Anthem Blue Access PPO available at: <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/indiana-ehb-benchmark-plan.pdf>;
 - United Healthcare POS; or
 - Advantage HMO; OR
- Meet the federal requirements for minimum value described at: <http://www.cms.gov/site-search/search-results.html?q=minimum%20value%20calculator> AND offer benefits in all of the following essential health benefit categories:
 - Ambulatory patient services,
 - Emergency services,
 - Hospitalization,
 - Maternity and newborn care,
 - Mental health and substance use disorder services,
 - Prescription drugs,
 - Rehabilitative and habilitative services and devices,
 - Laboratory services,
 - Preventive and wellness services and Pediatric services.
- 2) Health plan complies with abortion services in accordance with federal and state. Federal law prohibits funds from being used for abortion services referenced at <http://www.cms.gov/site-search/search-results.html?q=abortion%20for%20which%20federal%20funding%20is%20prohibited>. State law prohibits health plans from providing abortion services, except for rape, incest or when the life of the woman would be endangered, referenced at <https://iga.in.gov/legislative/laws/2014/ic/titles/027/articles/008/chapters/13.4/>.
- 3) Health plan complies with the Mental Health Parity and Addiction Equity Act (MHPAEA). The parity protections ensure that limits applied to mental health and substance use disorder services are not more restrictive than limits applied to medical and surgical services available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

Note: Program standards must be checked for each employer plan after the plan information is entered and saved.

Step 4b: Insurance Agent (Optional)

Applicants will be asked to enter the agent's contact information if requested by the employer.

Step 4c: Additional Employer Health Coverage

Applicants will be asked to provide the following dental or vision plan information, if offered by the employer:

- Plan Name and Policy ID for Dental or Vision
The policy ID is displayed on the dental/vision card or is the medical group ID.

Step 4d: Upload Employer Plan Information

Applicants will be asked to upload the information below about their health plan:

Note: Applicant may provide information for more than one plan.

- Upload the following plan information: Major Medical, Dental and Vision premium rates for each plan, if available. Include HRA employer annual contribution amounts for each plan, if applicable. Employers that offer an Early Retiree Program (ERP) must include premium rates if different from other employees.

Also for each plan upload Summary of Benefits and Coverage (SBC), Schedule of Benefits, Certificate of Coverage or Summary Plan Description and Prescription Drug Formulary for major medical; Benefits Summary for dental and vision; and Rider Benefits Summary, if applicable.

A description of these documents is available below at the [HIP Employer Link Application Reference](#) guide.

Step 4e: Health Coverage

Applicants will be asked to provide the following information about their health coverage:

- Type or tier of coverage provided by the health plan, such as employee/member, spouse or dependent
- Employer open enrollment period; include start date and end date
- Employer current annual benefit period; include coverage effective date and end date
- Waiting period prior to enrollment into the health plan
- Indicate if employer wellness program offered
- Indicate if applicant offers a health savings account (HSA) or health reimbursement account (HRA)

STEP 5: CONFIRM PROGRAM REQUIREMENTS AND SUBMIT SESSION II

Applicants will be asked to agree to the program's terms and submit the second part of the application.

APPLICATION REVIEW PROCESS

The Indiana Family and Social Services Administration (FSSA) will conduct a fair and comprehensive evaluation of HIP Employer Link applications based on the requirements and criteria as established by FSSA. The health plan submitted by each applicant will be reviewed to ensure benefit and affordability requirements are met.

FSSA will review applications within 30 days of receiving the complete application including the uploaded documents. Applicants will be contacted after submission of their application for an update on the review process. Once the application has been approved, the employer applicant will receive a HIP Employer Link ID. An employer that has been approved and has a HIP Employer Link ID may provide

the ID to employees to enter on the state enrollment application. After eligibility is determined and the enrollment process is complete, the member will receive premium assistance and help with out-of-pocket medical expenses for the employer-sponsored insurance.

HIP EMPLOYER LINK PORTAL REQUIREMENTS

Employers or multi-employer plans must respond to employee data requests sent from the state. FSSA will update the portal with employees that have been identified as eligible for HIP Employer Link. The eligible employees must first be verified by the employer. The employer will check such data as employment verification or membership and to provide employer health plan information for the employee, including coverage effective dates. On a monthly and annual basis, a request will be sent to verify the existing HIP Employer Link employees to ensure eligibility is maintained and confirm the employee premium amount. Additional information is provided in the [Verification of Employee Eligibility](#) section of the manual.

HIP EMPLOYER LINK EMPLOYER ANNUAL REQUIREMENT

On an annual basis, 60 days prior to the employer open enrollment period, the employer will be sent a notice from the state to confirm if the information provided in the application is current or to update the information that has changed. For employers, their health plan may change benefits or premium rates prior to annual renewal for the next benefit period. Employers may also add a new health plan for the subsequent plan year. The employer will need to update their profile or upload new health plan information for the state to review for benefit and affordability requirements for new plans or existing plan amendments at least 30 days prior to the start of the employer's open enrollment period. Additional information is provided in the [Annual Confirmation](#) section of the manual.

QUESTIONS

Applicants can direct questions or comments regarding the HIP Employer Link application process to the HIP Employer Link Team at HIPEmployerLink@fssa.in.gov or by contacting 1-800-457-4584.

HIP Employer Link Employer Application Reference

1. Certificate of Coverage or Summary Plan Description— This may be a 100-200 page document from your health insurance company. It details all the coverage and options of your health insurance plan. You might have the more than one Certificate of Coverage or Summary Plan Description for each plan.
2. Summary of Benefits and Coverage— This document is in a very specific format and looks like the example found here: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/sbc-template-accessible.pdf>. This is an Affordable Care Act (ACA) requirement for all health insurance plans. If you can't find a copy, ask your broker/agent or insurance company for assistance.
3. Benefit Summaries and Schedule of Benefits— This document may have been created by your insurance company. It's about two or three pages long and lists a general summary of benefits. It will also include such cost sharing as deductibles, maximum out-of-pocket limits or coinsurance rates for specific services.

4. Dental and/or Vision Coverage— These documents are generally one or two pages each and list the details of your vision and/or dental coverage, if offered to employees.
5. HRA Contributions— Provide documentation that lists the annual Health Reimbursement Account (HRA) contribution amount provided to your employees per tier, such as single or family. Also, include if the HRA amount is paid first before the employee covers out-of-pocket medical expenses or paid second after the employee. In addition, include any specific details to your HRA contribution arrangement.
6. Drug Formulary— This document may be five to ten pages long and lists the prescription drugs covered by the insurance company. The formulary is sometimes listed in one to four different tiers of coverage.
7. Employer and Employee Premium Contributions — Provide documentation that lists how much you pay (employer rate) and how much your employees pay (employee rate) for the health, dental and vision, if offered, insurance premiums. This will generally be broken down into the following tiers:
 - a. Employee
 - b. Employee + Spouse
 - c. Employee + Child(ren)
 - d. Family

Employer rates for dental and vision are not required. The premium amount may be annually, monthly or per pay based on your current payroll periods, such as bi-weekly. If you have a wellness program or other rating factors, such as tobacco and non-tobacco, also include the employer and employee premium rates for these rate levels.

If you have an Early Retiree Program (ERP), please include the premium rates for this program if they differ from other employees.

Additional Application Tips

- Documents cannot exceed 20MB. If the document exceeds this limit, you may separate the document as part 1 or part 2 or email the attachment to the HIP Employer Link Team at HIPEmployerLink@fssa.IN.gov.
- The file name of your documents cannot exceed 100 characters.
- **Your application cannot be processed until we have all the documentation.**
- If you have any changes to your initial application, please edit the application as soon as possible.

If you have questions, you may contact Sara Hall at 317-234-8030 or email the HIP Employer Link Team at HIPEmployerLink@fssa.IN.gov.

HIP Employer Link Employee Premium Payment Schedules

HIP LINK EMPLOYEE PREMIUM PRIMARY PAYMENT SCHEDULE 2016

Jan-16						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Jul-16						
S	M	T	W	TH	F	S
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24	25	26	27	28	29	30
31						

Feb-16						
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21	22	23	24	25	26	27
28	29					

Aug-16						
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21	22	23	24	25	26	27
28	29	30	31			

Mar-16						
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27	28	29	30	31		

Sep-16						
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Apr-16						
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Oct-16						
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30	31					

May-16						
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29	30	31				

Nov-16						
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27	28	29	30			

Jun-16						
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Dec-16						
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25	26	27	28	29		

- Cycle Date
- Premium Cycle Date

HIP Employer Link Out-Of-Pocket Reimbursement Form



HIP Employer Link Account Out-Of-Pocket Expense Reimbursement

Claim Form Note: This form is only for services received from providers that are not enrolled with the Indiana Health Coverage Programs. To search for enrolled providers, visit

<http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx>.

HIP Employer Link may reimburse the employee for amount(s) paid for services received by the individual or eligible family member from a provider who is not enrolled with the Indiana Health Coverage Programs, but is an in-network provider on the employer plan. The reimbursement amount will be the amount for the service received, reduced by the Medicaid allowable cost sharing limits.

Submit the following information for reimbursement:

- Name and RID of member who received the medical service,
- Last four digits of member's SSN,
- HIP Employer Link Employer ID,
- Provider bill or invoice,
- Receipt of payment, and
- Explanation of Benefits (EOB) for the appropriate service and date.

Instructions to Submit the above Information

Step 1: Fill Out the Form

Starting on the far left box please type or print in capital letters, with your letters centered in the middle of the boxes provided as shown below:

A	B	C	D		1	2	3	4
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Section 1

- Complete all areas of Member/Employee Information. You will need to provide your **HIP Employer Link RID number** and the last **four digits of your social security number**. **Failure to provide both will result in your request for reimbursement being rejected** and sent back with a letter explaining the reason for your rejection of your request.

Sections 2 & 3

- Do not group expenses; each expense must be listed individually as each expense will be processed separately and will be reflected as separate amounts on your account.
 - Complete all sections of the form including as many lines as needed. Sign and date the agreement at the bottom of the page after reading.
 - Please use section 3 to write expenses. You may attach more than one expense page if you have more expenses than fit on one page. Please attach all completed expense pages with Section 1 and 2 for submission.

Step 2: Attach Supporting Documentation

- In addition to completing each of the fields, you must provide supporting documentation for each payment in the form of:
 - FOR MEDICAL, DENTAL AND VISION REIMBURSEMENT:
 - Provider bill or invoice,
 - Itemized receipt for your payment to your medical, dental or vision provider and

- Explanation of Benefits (EOB) from your insurance company or health care provider.
- **FOR PRESCRIPTION REIMBURSEMENT:**
 - Receipt for payment of the prescription
 - Copy of the prescription fill information from the pharmacy attached to the prescription envelope, which includes:
 - Name of the patient for whom the item is prescribed
 - Name of the medication
 - Dosage requirement
 - Provider's address
 - Co-payment information

Step 3: Read the Certification, Sign and Date

- Please read carefully the Certification and then sign your name and write the date to accept the terms and conditions.
- Please **PRINT** legibly in **BLUE** or **BLACK** ink to complete this form. Failure to provide clear, complete, and accurate information will result in a non-paid expense(s). Remember to keep all originals and mail us a copy of the documents you are submitting. **DO NOT** group expenses; each expense **MUST** be listed individually.
- For additional assistance or information, call 1-800-457-4584 or visit www.in.gov/fssa/hip/2489.htm. For those who are hearing impaired, email HIP2.0@fssa.in.gov.

Step 4: Submit Your Form

- **Submit all forms by mail to:**
 HP/HIP Employer Link
 P.O. Box 1955
 Indianapolis, IN 46206-1995
- **Please use more than one Section 3 expense form if needed.**
- **Please DO NOT**
 - Email or fax your reimbursement form
 - Use red ink to complete this form
 - Use highlighter on any receipts or this form
 - Staple copied receipts together or on the form
 - Write outside the boxes
 - Circle applicable items on your receipts

DATE OF SERVICE: FROM (MM/DD/YY) DATE OF SERVICE: TO (MM/DD/YY) AMOUNT REQUESTED (DOLLARS .

CENTS)

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CHECK EXPENSE TYPE: MEDICAL DENTAL VISION PRESCRIPTION

INDIVIDUAL MEMBER RID THAT RECEIVED SERVICE INDIVIDUAL MEMBER NAME THAT RECEIVED SERVICE

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DATE OF SERVICE: FROM (MM/DD/YY) DATE OF SERVICE: TO (MM/DD/YY) AMOUNT REQUESTED (DOLLARS .

CENTS)

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