



Indiana Comprehensive Health Insurance Association



Applicant Guide

TABLE OF CONTENTS

| | |
|--|----------------|
| SECTION 1: DO YOU QUALIFY FOR ICHIA COVERAGE? | Page 2 |
| SECTION 2: WHAT ARE THE COVERED BENEFITS? | Page 4 |
| SECTION 3: WHAT ARE THE EXCLUSIONS? | Page 9 |
| SECTION 4: HOW ARE THE COVERED BENEFITS MANAGED BY ICHIA? | Page 11 |
| SECTION 5: HOW DO YOU APPLY FOR ICHIA COVERAGE? | Page 12 |



Thank you for your interest in the Indiana Comprehensive Health Insurance Association (ICHIA) healthcare coverage. ICHIA was created by the Indiana Legislature to offer an alternative for health insurance coverage to residents of Indiana who experience problems in obtaining or keeping health insurance due to a medical condition or other qualifying condition. If you have questions or would like to reach us, below is our contact information:

www.ichia.org – website

ICHIA - P.O. Box 33009, Indianapolis, IN 46203-0009 – Mailing Address

ACS - 4550 Victory Lane, Indianapolis, IN 46203 – Walk in Address (8am – 4pm)

1-800-552-7921 – toll free (8am – 4pm)

317-614-2133 – local (8am – 4pm)

SECTION I: DO YOU QUALIFY FOR ICHIA COVERAGE?

To be eligible for an ICHIA policy, you must meet **ALL** of the general requirements and **ONE** of the eligibility categories.

GENERAL REQUIREMENTS (You Must Meet All of These Requirements)

1. You must be a resident of the State of Indiana (A resident refers to a person who has resided continuously in the State of Indiana in a place of permanent habitation for at least 12 months immediately preceding application for insurance and throughout the period of your coverage). ***The residency requirement does not apply to applicants who are federally eligible.***
2. You are not eligible for Medicaid. ***The Medicaid requirement does not apply to applicants who are federally eligible.***
3. ***If you are on Medicare, you may still be eligible*** and your benefits will be coordinated with ICHIA Benefits. Options for Medicare Beneficiaries include: Plans 1, 2 and 3 medical coverage only and no pharmacy benefits – OR a choice of any plan that includes pharmacy. ICHIA is the payor of last resort and coordinates benefits with Medicare payments.

ELIGIBILITY CATEGORIES (You Must Meet ONE of These Category Requirements)

1. **Federally Eligible** - You are federally eligible if on the date you apply for coverage with ICHIA; you have had creditable coverage for at least 18 months with no lapse in coverage exceeding 63 days. Your most recent coverage must satisfy ***ALL the following requirements***: 1) have been under a group plan (through your or a family members' employer or union); 2) you are not eligible for coverage under any other group health plan; 3) you do not have other health insurance; 4) you are not eligible for Medicaid; 5) you did not lose your insurance for not paying the premiums or for committing fraud; and 6) if offered COBRA benefits, you must have exhausted your COBRA benefits. You can prove your creditable coverage with any of the following as long as they clearly establish 18 months of coverage with no lapse in coverage longer than 63 days: a copy of the Certificate of Health Plan Coverage provided by your previous insurance carrier / employer, a letter from the insurance carrier indicating your length of coverage, explanations of benefits (EOBs), other correspondence from a plan or issuer or paystubs that clearly establish 18 months of coverage with no lapse in coverage longer than 63 days. Federal eligibility is determined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which allows individuals to avoid a pre-existing condition waiting period when changing from one carrier to another.
2. **Rejection for Other Health Coverage** - Received notification of rejection from a health insurer for coverage that equals or exceeds the MINIMUM requirements for accident or sickness insurance policies issued in Indiana.
3. **Premium Rate Higher Than ICHIA** - You received a premium notice for health insurance coverage exceeding the premium rate for coverage by ICHIA. However, you must not be eligible for any coverage that equals or exceeds the minimum requirements for accident and sickness policies in Indiana.

DEPENDENT ELIGIBILITY

Coverage for your spouse and / or children is also available based on the following Limiting Age requirement.

An unmarried dependent child's coverage will terminate on the earlier of the child's 24th birthday, or the child's 25th birthday, if the child is a full-time student in an accredited high school, technical or vocational school, or college or university and is chiefly dependent on you for support and maintenance.

Attainment of the limiting age will not terminate a child's coverage if the child is:

- Incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and
- Chiefly dependent on you for support and maintenance.

Proof of such incapacity and dependency must be furnished within 120 days of the child's attainment of the limiting age, and subsequently as ICHIA requires, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Newborn Children: Your newborn child is automatically covered for the first 31 days after birth. Coverage for the first 31 days is subject to the annual deductible, coinsurance, and out-of-pocket maximum. The coverage for newly born children consists of coverage of Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If you wish to continue the child's coverage beyond the first 31 days and add the child as a dependent under this Policy, you must contact us before the end of the 31-day period to request a dependent application and you will be required to pay the necessary premium. If you do not add the child as a dependent, the newborn's coverage terminates at the end of the 31-day period after birth.

Adopted Children: The coverage for newly adopted children will be the same as for other dependents. Coverage for an adopted child is effective upon the earlier of:

- the date of placement for the purpose of adoption; or
- the date of the entry of an order granting you custody of the child for purposes of adoption; and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement for 31 days. If you wish to continue the child's coverage beyond the first 31 days and add the adopted child as a dependent under this Policy, you must contact us before the end of the 31-day period to request a dependent application. You will be required to pay the necessary premium. If you do not add the adopted child as a dependent, the child's coverage terminates at the end of the 31-day period after adoption or placement for adoption.

Your final eligibility will be determined by Indiana Comprehensive Health Insurance Association (ICHIA) in accordance with statute IC 27-8-10-10.

ICHIA has established eligibility guidelines to prohibit: (1) employer (2) insurance agent; or (3) insurance broker from placing in or referring to ICHIA an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002). Declination by the employer's carrier does not guarantee eligibility for ICHIA.

SECTION 2: WHAT ARE THE COVERED BENEFITS?

Covered Benefits can vary by plan and include various levels of Inpatient Hospital, Mental Illness and Substance Abuse, Prescription Drugs, Professional Services (office visits), Skilled Home Healthcare, Skilled Nursing Facilities, Surgical Expenses, Transplant Services, and Hospice Services.

See the benefit chart on the following pages to determine the plan differences.

If you are applying as a Medicare Beneficiary you can choose any of the Plans below for full coverage OR you can choose Plan 1, Plan 2 and Plan 3 MEDICAL BENEFITS ONLY without pharmacy coverage which on your application are designated as:

PLAN 1 Rx - THIS IS THE SAME AS PLAN 1 COVERAGE DETAILED ON THE FOLLOWING PAGES WITH MEDICARE PART D (INSTEAD OF ICHIA'S PHARMACY COVERAGE)

PLAN 2 Rx - THIS IS THE SAME AS PLAN 2 COVERAGE DETAILED ON THE FOLLOWING PAGES WITH MEDICARE PART D (INSTEAD OF ICHIA'S PHARMACY COVERAGE)

PLAN 3 Rx - THIS IS THE SAME AS PLAN 3 COVERAGE DETAILED ON THE FOLLOWING PAGES WITH MEDICARE PART D (INSTEAD OF ICHIA'S PHARMACY COVERAGE)

REFER TO THE PREMIUM RATE TABLE PAMPHLET LOCATED IN THIS PACKET TO SEE THE DIFFERENCE IN COST FOR EACH OF THESE PLANS. IF YOU ARE A MEDICARE BENEFICIARY AND WISH TO PURCHASE ONLY THE MEDICAL SERVICES OF A PLAN WITHOUT PHARMACY, PLEASE UTILIZE THE MEDICARE BENEFICIARY RATE GUIDE.

If you are enrolled in **Medicare Part A** and are not enrolled in **Medicare Part B**, you need to be aware that ICHIA will not be responsible for the dollars that Medicare would have paid had you been enrolled in **Medicare Part B**.

Medicare Part A is defined as hospital insurance which helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home healthcare and hospice care. **Medicare Part B** is defined as insurance that helps pay for doctors' services, diagnostic tests, ambulance services, durable medical equipment and other healthcare services.

The following exclusion is listed in the ICHIA policy:

- Charges Medicaid or Medicare paid, or for which Medicaid or Medicare would have been liable for, if the Insured had enrolled in those programs.

If you have **Medicare Part A** but do not have **Medicare Part B**, you can sign up for **Medicare Part B** during a general enrollment period. A general enrollment period is held January 1 through March 31 each year.

Insurance Counseling and Assistance programs are located in every state. These programs have volunteer counselors who can give you free assistance with Medicare questions, including enrollment, entitlement and premium issues. In Indiana the Senior Health Insurance Information Program (SHIIP) can assist you. They can be reached at 1-800-452-4800. You can also call 1-800-633-4227 or visit www.medicare.gov.



| BENEFITS AND PLAN FEATURES | | Plan 1 & Plan 1 Rx |
|---|--|---|
| MEDICAL DEDUCTIBLE - The portion of MEDICAL healthcare expenses a member must pay out-of-pocket before any insurance coverage applies or reimbursement by ICHIA for expenses begins. | \$500 | |
| PHARMACY DEDUCTIBLE - The portion of PRESCRIPTION DRUGS / PHARMACY expenses a member must pay out-of-pocket before any insurance coverage applies or reimbursement by ICHIA for expenses begins. This is in addition to your MEDICAL DEDUCTIBLE UNLESS YOU CHOOSE PLAN 4. If you are a Medicare Beneficiary and want a Medical only Plan (1 Rx, 2 Rx, or 3 Rx), this does not apply to you. | \$550 | NOT APPLICABLE IF YOU ARE CHOOSING THE MEDICARE PLAN THAT DOES NOT COVER Rx – PLAN 1 Rx |
| COINSURANCE - The set percentage of the cost of covered services that are an out-of-pocket payment by the member. The amount of coinsurance differs if you go to an in-network provider or an out-of-network provider. | You Pay 20% for in-network services. You Pay 40% for out-of-network services. | |
| COPAYMENT - The dollar amount you must typically pay at the time of service that is your responsibility and is based on the type of service(s) received. | Emergency Room - \$100 copay (unless you are admitted to the hospital at the time of your emergency visit). | |
| OUT-OF-POCKET MAXIMUM (including deductible and coinsurance) - The limit that is placed on how much the member's share of eligible expenses are per calendar year (deductible + coinsurance) before ICHIA pays 100% of eligible expenses for the remainder of the calendar year. | \$1,500 | |
| INPATIENT & HOSPITAL SERVICES - Inpatient and Hospital Services can vary by plan. Review each plan benefit description in this chart for differences in coverage. Your deductibles and copay also apply to this benefit. | Services up to 180 days per calendar year paid at a semi-private room rate unless a private room is medically necessary. | |
| PROFESSIONAL SERVICES – Professional Services which are rendered by a physician for the treatment of a medical condition is the same for all plans. Your specific plan deductibles and copay applies to this benefit. | Services rendered by your Physician are covered up to policy maximums and copay of your plan. | |
| MENTAL ILLNESS / SUBSTANCE ABUSE – Inpatient and Outpatient Services related to Mental Illness and Substance Abuse Treatment can vary by plan. Review each plan benefit description in this chart. Your deductibles and copay also apply to this benefit. | Outpatient: 30 outpatient visits per year combined. Inpatient: Services covered in the same manner as any other illness. | |
| SKILLED NURSING FACILITY - As an alternative to hospital confinement, your provider may prescribe admission to a skilled nursing facility. The benefit of 180 days is the same for all plans. Your specific plan deductibles and copay applies to this benefit. | Services up to 180 days per calendar year are covered, provided confinement meets the criteria outlined in the policy. Precertification is required. | |
| SURGICAL EXPENSES – Surgical Expenses are expense incurred during surgery. These benefits are the same for all plans. Your specific plan deductibles and copay apply to this benefit. Second Surgical Opinion is an option in your plan elective. Plan will pay 100% of the usual and customary allowance for the second opinion. | 100% of the usual and customary allowance for the second opinion. | |

*Plan 5 available as of January 1, 2011.

----- PLANS AVAILABLE -----

| Plan 2 & Plan 2 Rx | Plan 3 & Plan 3 Rx | Plan 4 | Plan 5* |
|--|--|---|---|
| \$1,000 | \$1,500 | \$2,500 - Plan 4 has a shared medical and pharmacy deductible | \$5,000 - Plan 5 has a shared medical and pharmacy deductible |
| \$450 NOT APPLICABLE IF YOU ARE CHOOSING THE MEDICARE PLAN THAT DOES NOT COVER Rx – PLAN 2 Rx | \$550 NOT APPLICABLE IF YOU ARE CHOOSING THE MEDICARE PLAN THAT DOES NOT COVER Rx – PLAN 3 Rx | \$2,500 - Plan 4 has a shared medical and pharmacy deductible | \$5,000 - Plan 5 has a shared medical and pharmacy deductible |
| Same as Plan 1 | Same as Plan 1 | Same as Plan 1 | Same as Plan 1 |
| Same as Plan 1 | Same as Plan 1 | Same as Plan 1 | Same as Plan 1 |
| \$3,000 | \$4,000 | \$5,000 | \$5,900 |
| Services up to 365 days per calendar year paid at a semi-private room rate unless a private room is medically necessary. | Same as Plan 2 | Same as Plan 1 | Same as Plan 1 |
| Same as Plan 1 | Same as Plan 1 | Same as Plan 1 | Same as Plan 1 |
| \$50,000 lifetime benefit for mental illness / substance abuse combined. MENTAL ILLNESS: Inpatient – 60 days / yr. Outpatient - 50 visits / yr; \$30 / visit SUBSTANCE ABUSE: Inpatient- 30 days consecutive per 365 day period. No more than two such 30 day periods during contract lifetime. Outpatient - 60 visits / lifetime. | Same as Plan 2 | Same as Plan 1 | Same as Plan 1 |
| Same as Plan 1 | Same as Plan 1 | Same as Plan 1 | Same as Plan 1 |
| Same as Plan 1 | Same as Plan 1 | Same as Plan 1 | Same as Plan 1 |

| BENEFITS AND PLAN FEATURES | | Plan 1 & Plan 1 Rx |
|---|--|---|
| SKILLED HOME HEALTHCARE – Skilled Home Healthcare Services which include home infusion therapy can vary by plan. Review each plan benefit description in this chart. Your deductibles and copay also apply to this benefit. | | Services for 270 visits each calendar year (as described in the policy), but may not exceed \$150 for each day. ICHIA does not cover custodial care. Precertification applies to home infusion therapy. |
| PRESCRIPTION DRUGS / PHARMACY BENEFITS – Medco Administers the Pharmacy Benefits for ICHIA. Please contact Medco for additional information or a listing of the formulary drugs at www.medco.com or call Member Services at 1-877-841-5249. TTY/TDD users should call 1-800-759-1089. | | Retail Location: 30 Day Supply \$16 Generic Copay \$28 Formulary Copay \$44 Non-formulary Copay Mail Order: 90 Day Supply \$40 Generic Copay \$60 Formulary Copay \$100 Non-formulary Copay NO COVERAGE IF YOU ARE CHOOSING THE MEDICARE PACKAGE WITH NO ICHIA RX (Plan 1 Rx) AND USING MEDICARE PART D AS YOUR PHARMACY COVERAGE |
| TRANSPLANT SERVICES - Transplant Services which are services rendered in relationship to a covered transplant can vary by plan. Your specific plan deductibles and copay apply to this benefit. | | Transplant services are covered without a benefit limit. |
| HOSPICE SERVICES - Hospice Services include Hospice care that may be provided in the home or at a Hospice facility for end-of-life care designed to meet the member's medical, social and psychological needs. Hospice care is available for patients with a terminal illness and life expectancy of six months or less as certified by their physician. Hospice includes routine home care, continuous home care, Inpatient Hospice and Inpatient respite care. Covered Services include the following after authorization. Your specific plan deductibles and copays apply to this benefit. <ul style="list-style-type: none"> • Skilled Nursing Services (by an R.N. or L.P.N.) • Diagnostic Services • Physical, speech and inhalation therapies • Medical supplies, equipment and appliances • Counseling services, including bereavement counseling • Inpatient confinement at a hospice facility • Prescription Drugs to end disease or dying process • Respite Care | | Hospice services are covered without a benefit limit |

*Plan 5 available as of January 1, 2011.

Going out of the PPO network will increase the amount of out-of-pocket expenses you

| | | \$100 Office Visit | |
|----------------|---|--|-------|
| | | YOU PAY | ICHIA |
| Out-of-Network | \$100 Office Visit <u>x 20%</u> Coinsurance \$20 You Pay | \$100 Office Visit <u>x 80%</u> Coinsurance \$80 ICHIA Pays | |
| | \$100 Office Visit <u>x 40%</u> Coinsurance \$40 You Pay | \$100 Office Visit <u>x 60%</u> Coinsurance \$60 ICHIA Pays | |

----- PLANS AVAILABLE -----

| Plan 2 & Plan 2 Rx | Plan 3 & Plan 3 Rx | Plan 4 | Plan 5* |
|--|---|----------------|----------------|
| Services for 270 visits each calendar year (as described in the policy), but may not exceed \$60 for each day. ICHIA does not cover custodial care. Precertification applies to home infusion therapy. | Same as Plan 2 | Same as Plan 1 | Same as Plan 1 |
| Same as Plan 1 NO COVERAGE IF YOU ARE CHOOSING THE MEDICARE PACKAGE WITH NO ICHIA RX (Plan 2 Rx) AND USING MEDICARE PART D AS YOUR PHARMACY COVERAGE | Same as Plan 1 NO COVERAGE IF YOU ARE CHOOSING THE MEDICARE PACKAGE WITH NO ICHIA RX (Plan 3 Rx) AND USING MEDICARE PART D AS YOUR PHARMACY COVERAGE | Same as Plan 1 | Same as Plan 1 |
| Benefits are limited to \$250,000 during lifetime, including payments made on your behalf to donors. ICHIA will pay eligible expenses as any other sickness and the donor's eligible expenses as if the expense was incurred by you; this includes both pre- and post-transplant expenses. | Same as Plan 2 | Same as Plan 1 | Same as Plan 1 |
| Same as Plan 1 | Same as Plan 1 | Same as Plan 1 | Same as Plan 1 |

you incur. The examples below illustrate how using a PPO provider saves you money.

| | \$1000 Hospital Visit | |
|------|--|---|
| PAYS | YOU PAY | ICHIA PAYS |
| | \$1000 Hospital Visit x 20% Coinsurance \$200 You Pay | \$1000 Hospital Visit x 80% Coinsurance \$800 ICHIA Pays |
| | \$1000 Hospital Visit x 40% Coinsurance \$400 You Pay | \$1000 Hospital Visit x 60% Coinsurance \$600 ICHIA Pays |

DEDUCTIBLE - The amount of allowable expenses that must be incurred and paid by you in a calendar year before benefits become payable by ICHIA. The first calendar year begins on the effective date of the policy and ends on December 31 of that same year. No more than one deductible must be satisfied by each insured during a calendar year. You may elect to change to a Plan with a higher deductible. No changes are allowed to a Plan with a lower deductible. Any Plan changes in coverage under this policy are effective January 1.

COINSURANCE - Coinsurance is the percentage of allowable expenses you pay after the deductible has been satisfied. Coinsurance amounts are **in addition to** any charges incurred due to using an out-of-network provider (such as charges over the usual and customary allowance).

OUT-OF-POCKET EXPENSE LIMIT - The out-of-pocket maximum represents the total dollar amount, including the deductible and coinsurance that you will have to pay toward allowable expenses in a calendar year. This does not include your separate pharmacy amount.

When your out-of-pocket maximum is reached in each calendar year, ICHIA will pay 100% for additional allowable expenses incurred by that insured, up to the benefit maximums, for the remainder of that calendar year. When the family out-of-pocket maximum is reached, ICHIA will pay 100% of the additional allowable expenses incurred by all insureds under this policy for the remainder of that calendar year.

SECTION 3: WHAT ARE THE EXCLUSIONS?

There are specific **Exclusions** in the policy document that can be reviewed on www.ichia.org. A summary of exclusions is provided below:

Check the exclusions before receiving services.

Cosmetic Care and Related Supplies - Any services performed in connection with cosmetic surgery for a nonfunctional condition or for any condition that existed on the effective date of the enrollee's coverage. ICHIA will cover: a) services required as a result of an injury received while insured under this policy; b) repair of congenital defects of newborn children and birth defects if the insured is under age 12 or if he / she was under age 12 when first surgically treated for the condition; c) otherwise covered medical expenses that are an integral part of such surgery; d) services required as a result of previous medically necessary surgery if the insured had uninterrupted coverage with us from the date of the previous surgery.

Custodial Care - Services or treatment which, regardless of where it is provided: a) could be rendered safely by a person without medical skills; and b) is designed mainly to help the patient with daily living activities, including (but not limited to); 1) personal care such as help in walking, getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema; and using the toilet; 2) homemaking such as preparing meals or special diets; 3) moving the patient; 4) acting as companion or sitter; 5) supervising medication which can usually be self-administered; 6) oral hygiene; and 7) ordinary skin and nail care.

Dental Prosthetics and Surgery - Dental prosthetics and oral and dental surgery are excluded. Care or supplies received from a dental or medical department run by an employer, mutual benefit association, labor union, trust, or similar person or group to the extent you have no obligation to pay for them is also excluded.

Medicaid Charges - Charges paid by Medicaid or for which Medicaid is liable.

Experimental Drugs - Prescription drugs that are not, in the opinion of the Food and Drug Administration (FDA), scientifically proven as effective in treating the condition, diagnosis or illness for which their use is proposed.

Experimental Procedures - Healthcare services which are unproven by scientific evidence or generally not accepted by informed healthcare professionals in the U.S. as effective in treating the condition, diagnosis or illness for which their use is proposed.

Medicare Charges - Charges paid by Medicare or for which Medicare is liable.

Nursing - Private duty nursing care or services of special nurses except as outlined in the Home Healthcare section under Covered Benefits.

Pharmacy Exclusions - Please contact Medco to obtain a list of pharmacy exclusions.

Pre-existing Conditions - Any condition or illness that existed on or before the effective date of coverage with ICHIA and for which medical treatment or advice was recommended or received within a period of three months before the effective date of coverage.

Personal Comfort Items - Any personal comfort item such as televisions, barber or beauty services.

Services or Supplies - Services or supplies which are not medically necessary, medically appropriate, or are experimental in nature for the diagnosis or treatment of a specific illness.

Workers' Compensation Charges - Charges paid under Workers' Compensation or Occupational Disease Law requirements.

PRE-EXISTING CONDITIONS

A pre-existing condition is any condition or illness that existed on or before the effective date of coverage with ICHIA and for which medical treatment or advice was recommended or received within the three months before your effective date of coverage.

You qualify for a Pre-Existing Condition Waiver if you lost your health insurance coverage within six months from the date of your application for coverage with ICHIA and provide a Certificate of Creditable Coverage from your previous health insurer / employer.

If you do not qualify for the Pre-Existing Condition Waiver, ICHIA excludes payment of benefits for the first three months following the policy effective date for any injury or illness deemed a pre-existing condition. If a claim is submitted that appears to be a pre-existing illness or condition, information will be requested from your provider regarding the diagnosis to determine if any treatment or advice was given.

After the pre-existing condition waiting period of three months has been satisfied, ICHIA will cover charges related to the pre-existing condition according to your Plan's schedule of reimbursement.

If you qualify for an ICHIA policy under the Federally Eligible category, you cannot be denied coverage for a condition, based upon the fact that the condition was present before the first day of coverage, regardless of whether any medical advice, diagnosis, care or treatment was recommended or received before that day.

Request a policy for a complete listing of exclusions by calling ACS Customer Service or by logging on to www.ichia.org

SECTION 4: HOW ARE THE COVERED BENEFITS MANAGED BY ICHIA?

You have a choice of 4 different benefit plans discussed in the previous section. Each of the benefit plans are managed through your ICHIA service team which include the following companies:



ACS provides all General Administration including Enrollment, Customer Service, Claims Payment, Premium Billing, and the Financial Management of the ICHIA Program.



APS Healthcare provides all Care Coordination and Authorization Services including Condition Management and Pre-Certification Services. Condition Management is part of the *ICHIA Healthy Together Program* for certain illnesses or conditions. *Healthy Together* is a free and confidential program that is required for all eligible ICHIA members with the specified illnesses or conditions.



Anthem Blue Cross and Blue Shield (Anthem)* provides the Preferred Provider Organization (PPO) of doctors and hospitals for ICHIA which represents a full range of medical specialties and includes hundreds of specialists across Indiana to provide the best medical care available. When you use a PPO provider, ICHIA will pay a higher percentage of the covered benefit costs. If you use a provider outside of the PPO, your payment responsibility will be higher.



Medco provides the Pharmacy Benefit Management Services and ICHIA members should go to one of the pharmacies in the Medco Network for prescription drugs. Members have access to a nationwide network of pharmacies which include places like your local drugstores, CVS national chains, etc. Through the Medco pharmacy locations, members will benefit from negotiated discounts on prescription drugs upon presenting their Medco pharmacy card.

*Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of Blue Cross and Blue Shield Association®. Anthem is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names are registered marks of the Blue Cross and Blue Shield Association.

SECTION 5: HOW DO I APPLY FOR ICHIA COVERAGE?

It's easy to apply.

NOTE: Steps 1 and 2 do not apply to federally eligible individuals.

Step 1: You must apply to Medicaid within 60 days prior to sending an application to ICHIA.

Step 2: Provide Proof of Medicaid Application by providing a copy of your application or verification that you have applied for Medicaid. A form is included in this packet for you to complete. You can go to www.in.gov/fssa (click on Apply for Benefits) to download a Medicaid application and eligibility information.

Step 3: Select the Plan that is right for you. Once you have determined which Plan is right for you, you can determine what your premium payment will be. Complete the enclosed application and return it with your **first two months premium** to the address on the form.

Your Employer is NOT allowed to pay your premiums. This can cause your coverage to be denied or terminated in the future.

Your effective date of coverage will be the later of: 1) the date the application is approved, 2) the day after your previous major medical coverage ends, or 3) a future date you request not to exceed 60 days.

All sections of the application must be completed in their entirety. A checklist is provided with your application to help guide you through the application process. Remember, premium payment is due at the time of application and all payments are deposited immediately upon receipt.

If at any time while completing the application you have questions, please contact our customer service department at 1-800-552-7921 or 317-614-2133.

You can also visit us on-line at www.ichia.org where you can view additional information about the ICHIA Plan or use our Ask-a-CSR inquiry system to send an electronic message to a customer service representative (CSR). If you wish to get a password for ichia.org, please call 1-800-511-5774 ext. 4444 and give the information requested.

Once your application is approved, you will receive a medical ID card, a pharmacy ID card, an out-of-state card, and other specific details about your benefits and the procedures you need to follow to get the maximum benefits to which you are entitled.





1-800-552-7921
www.ichia.org