



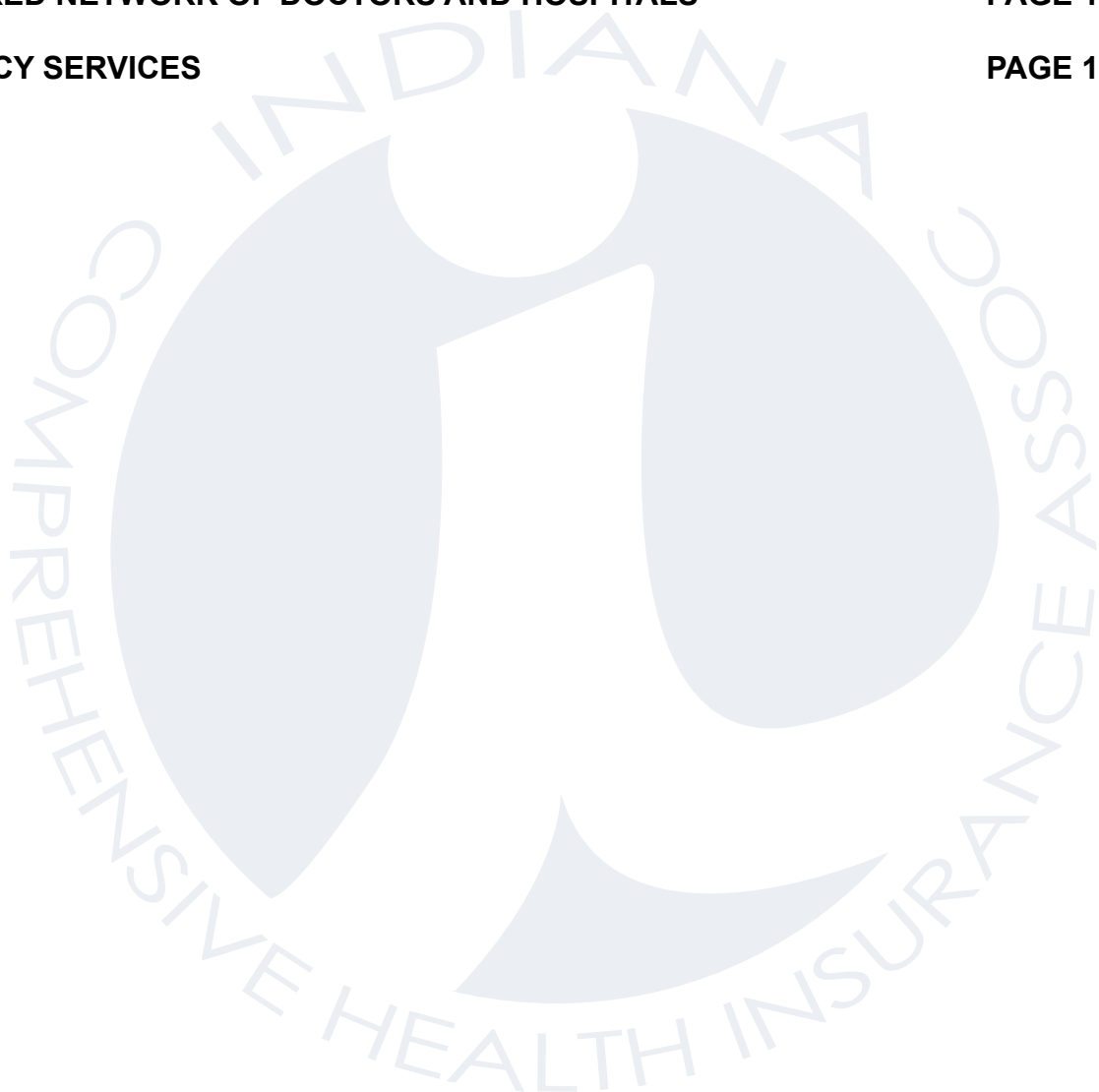
# Indiana Comprehensive Health Insurance Association



***Member Guide***

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## WELCOME TO ICHIA (INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION)

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. The program offers health benefits including physician services, mental health services, prescription drug coverage, and hospital care. ICHIA works with several organizations to manage your healthcare benefit program:



**ACS provides all General Administration** including Enrollment, Customer Service, Claims Payment, Premium Billing, and Financial Management of the 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. The *Healthy Together program* is free and confidential and 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 is where members should go for prescription drugs. Members have access to a nationwide network of pharmacies. Through the Medco pharmacies, members will benefit from negotiated discounts on prescription drugs upon presenting their Medco pharmacy card. The pharmacy deductibles differ by plan.

As a member of ICHIA, you will receive information from the various organizations above who manage your plan (ACS, APS Healthcare, Anthem, and Medco). Please open and review all information from these companies as it is important to your ICHIA medical program.

This Summary Benefits Guide is only a summary of Covered Services. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of your ICHIA Policy. We encourage you to obtain a copy of the Policy by logging on to [www.ichia.org](http://www.ichia.org) or you can contact ACS Customer Service Toll Free at 1-800-552-7921 or Local in Indianapolis at 317-614-2133 and request a hard copy.

\* 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.



**WE'RE HERE TO HELP.  
ACS PROVIDES GENERAL ADMINISTRATION SERVICES.**

ICHIA has contracted with ACS to help you answer any questions, concerns, complaints, or requests you may have regarding ICHIA providers, medical bill payments, or covered benefits.

**You can contact Customer Service in any of the following ways:**

**Go on-line to [www.ichia.org](http://www.ichia.org) - Website  
Call Toll Free at 1-800-552-7921 / Local in Indianapolis 317-614-2133**

**Write To:  
ICHIA  
Attn: Customer Service  
P.O. Box 33009, Indianapolis, IN 46203-0009**

**Visit our Administrator Office:  
ACS Health Care Solutions (ACS)  
4550 Victory Lane, Indianapolis, IN 46203**

Customer Service business hours are 8:00 am to 4:00 pm EST Monday through Friday. We are open for business 24 hours a day, 7 days a week via the internet.

#### **ICHIA WEB SERVICE**

It's easy to get information about your benefits through the ICHIA Website. The ICHIA Website is designed for members to find ICHIA information quickly and easily.

**The ICHIA website is located at [www.ichia.org](http://www.ichia.org)**

On the website you can:

1. Find a list of doctors, hospitals, pharmacies and other providers in your network
2. Print necessary forms
3. Get a Full ICHIA Insurance Policy
4. Get secure, personal and private healthcare information specifically for you that includes information about the services you have received and your benefits.

Using the **E-SERVICE** feature is **EASY, FAST** and **CONVENIENT**.

1. Log on to [www.ichia.org](http://www.ichia.org)
2. Click the Member Sign-In button. Enter your **User Name** (the 11 digit policy number from your identification card) and the **Password** you received in the mail.

**NOTE:** Please do not use dashes when entering your User Name and Password.

3. Choose an option from the list ranging from viewing your claims history to sending an email to customer service.

If you misplaced or have forgotten your password, contact customer service at 1-800-552-7921 for assistance.

**FAST** - Information about your health plan is available at your fingertips. You can download forms, request a new ID card, check claim payment status, search for a provider or contact customer service through email. All customer service inquiries are responded to within the next business day.

**CONVENIENT** - We are open for business 24 hours a day, 7 days a week via the internet. The e-service option allows you to access information about your health plan any time, day or night.

## PLAN 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 chart on the following pages to determine the plan differences.

**If you are a Medicare Beneficiary with MEDICAL BENEFITS ONLY without pharmacy coverage your plan benefits are listed under the appropriate plan and are referred to as Plan 1 Rx, Plan 2 Rx and 3 Rx. Your Benefits are identical to Plan 1, Plan 2, or Plan 3 EXCEPT you have no pharmacy benefits or pharmacy benefit deductible.**

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 if you were 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](http://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
<p>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.</p> <p><b>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.</b></p>	<p>\$550</p> <p>NOT APPLICABLE IF YOU ARE CHOOSING THE MEDICARE PLAN THAT DOES NOT COVER Rx – PLAN 1 Rx</p>
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.	<p>You Pay 20% for in-network services.</p> <p>You Pay 40% for out-of-network services.</p>
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.	<p>Outpatient: 30 outpatient visits per year combined.</p> <p>Inpatient: Services covered in the same manner as any other illness.</p>
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"> <li>• Skilled Nursing Services (by an R.N. or L.P.N.)</li> <li>• Diagnostic Services</li> <li>• Physical, speech and inhalation therapies</li> <li>• Medical supplies, equipment and appliances</li> <li>• Counseling services, including bereavement counseling</li> <li>• Inpatient confinement at a hospice facility</li> <li>• Prescription Drugs to end disease or dying process</li> <li>• Respite Care</li> </ul>		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 <b>\$20 You Pay</b>	\$100 Office Visit <u>x 80%</u> Coinsurance <b>\$80 ICHIA Pays</b>	
	\$100 Office Visit <u>x 40%</u> Coinsurance <b>\$40 You Pay</b>	\$100 Office Visit <u>x 60%</u> Coinsurance <b>\$60 ICHIA Pays</b>	

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 <b>\$200 You Pay</b>	\$1000 Hospital Visit x 80% Coinsurance <b>\$800 ICHIA Pays</b>
	\$1000 Hospital Visit x 40% Coinsurance <b>\$400 You Pay</b>	\$1000 Hospital Visit x 60% Coinsurance <b>\$600 ICHIA Pays</b>

## EXCLUSIONS

There are specific Exclusions in the policy document that can be reviewed on [www.ichia.org](http://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 for treating an illness, diagnosis or condition for which their use is proposed.

**Experimental Procedures** - Healthcare services which are unproven by scientific evidence or generally not accepted by informed health care 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.

**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.

**Pharmacy Exclusions** - Please contact Medco for all Pharmacy Exclusions.

**Impotency** - Services and supplies related to sex transformation, or male or female sexual or erectile dysfunction or inadequacies, regardless of origin or cause. This exclusion includes penile prosthesis or implants, vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment used in the treatment of impotency.

## 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 ICHIA Customer Service or log on to [www.ichia.org](http://www.ichia.org)**

## PREMIUM PAYMENTS

Premium rates are based on the geographic area of Indiana in which you reside, your age and your sex. Your premium rates are subject to change as you get older and move into a different age bracket or as the market rates demonstrate a need for a rate change. When a rate increase affects the entire population due to market rates, ICHIA will advise you of the change in writing 30 days in advance of the rate change.

Premium rates can only change when the same change is made on all policies, with the same provisions and benefits issued to persons of the same classifications and living in the same geographic region.

To request a current premium rate table, contact customer service at 1-800-552-7921 or calculate your premium on-line at [www.ichia.org](http://www.ichia.org). ICHIA offers several different payment cycles, including three monthly premium payment options - you can receive your premium invoice each month via U.S. mail, have your premium automatically deducted from your bank account by completing an authorization form or bill your credit card by filling out the credit card withdrawal form.

The automatic premium withdrawal authorization form and the credit card withdrawal form can be downloaded from our web site at [www.ichia.org](http://www.ichia.org) or you can request either form by calling customer service at 1-800-552-7921. A quarterly payment option is also available via U.S. Mail and quarterly EFT. At any time, you can change your premium payment cycle by sending us a request in writing at least 60 days prior to the new payment cycle taking effect. You must complete your current payment cycle before changing cycles (for example, if you are on the quarterly payment cycle, the entire quarter must be satisfied prior to moving to a monthly payment cycle).

All premium payments should be made by check or money order payable to ICHIA. Please include your premium invoice or write your policy number on the check or money order to ensure proper credit to your account.

Send premium payments to:  
ICHIA  
C/O Key Bank  
P.O. Box 711418  
Cincinnati, OH 45271-1418

## **POLICY RENEWAL**

Your ICHIA policy is renewed each time you pay the required premium by the due date or within the 31-day grace period that follows. Your policy cannot be terminated because of the number of claims or the amount of benefits you receive.

Your policy will terminate on the earliest of the following:

- the date you no longer meet the eligibility requirements;
- the first date you are no longer a resident of Indiana;
- the date you become eligible for Medicare; those under 65 and on Medicare due to a disability are still eligible and will not be terminated;
- the 45th day after the date on any inquiry we make concerning your place of residence, employment or other coverage if you have not responded to us within that time;
- the date we receive your request to end this policy or a future date;
- the date Indiana law requires cancellation of this policy;
- the effective date of your Medicaid coverage;
- the date you have equivalent coverage under another group plan.

**If ICHIA does not receive a required premium within thirty-one (31) days from the due date on your invoice, your ICHIA coverage will end.**

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

## **FILING AN APPEAL**

ICHIA believes in providing a high quality health plan for its membership. For that reason, procedures are in place that provide enrollees with the ability to express their dissatisfaction with any portion of the program. We hope you will never experience dissatisfaction, but at the same time, want to make a process available to you in order for your comments to be heard or to seek reconsideration of a health plan decision.

An appeal means any dissatisfaction expressed orally or in writing by or on behalf of an enrollee of ICHIA, within 60 days of a decision, regarding: a) the availability, delivery, appropriateness or quality of healthcare services; b) the handling or payment of claims for healthcare services or; c) matters pertaining to the contractual relationship between an enrollee and ICHIA; and for which the enrollee has reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.

The appeals procedure begins when an enrollee or his / her representative contacts the Administrator at their address or phone number and makes an appeal. If the appeal is initiated by anyone other than the enrollee, we need a signed personal representative form.

The following steps will be taken upon receipt of an appeal: a) the Administrator will document receipt of the appeal, including the date received, nature of the complaint and the ultimate resolution; b) the Administrator will notify the enrollee or his / her representative by mail of the disposition of the appeal. If the appeal is denied in whole or in part, the enrollee will be notified of the right to appeal the decision of the Administrator.

## **FILING A GRIEVANCE OF AN APPEAL DECISION**

The grievance procedure begins when an enrollee or his / her representative sends written notification to the Administrator at the address on the following page requesting review of the Administrator's appeal decision.

The written notification must be mailed within 60 days from the date on the letter notifying the enrollee of the right to file a grievance. The enrollee or his / her representative may include an explanation of the reason(s) why the decision should be different.

The Administrator will mail a written acknowledgement of the grievance to the enrollee or his / her representative within five business days after the grievance is received. The acknowledgement will include the date the grievance was received and the name, address and telephone number of an individual to contact regarding the grievance. ICHIA will appoint a Grievance Committee composed of individuals who have sufficient experience, knowledge and training to appropriately resolve a grievance.

An enrollee or a representative wishing to appear before the Grievance Committee in person to present the appeal, may do so by contacting the Administrator at the address provided in the notice to the enrollee of the right to file a grievance on the appeal decision.

The Grievance Committee will investigate and resolve the grievance in an expeditious manner.

The enrollee will be notified by mail of the resolution of the grievance within 45 days after the grievance is filed or five business days after completion of the investigation.

Written notification of the resolution of the grievance will include: a) a statement of the Grievance Committee's understanding of the enrollee's grievance; b) a description of the resolution reached by the Grievance Committee and the contract basis or medical rationale for the resolution stated in clear terms; c) a reference to the evidence or documentation used as a basis for the resolution; d) a notice of the enrollee's right to further remedies allowed by law; and e) the department, address and telephone number through which an enrollee may contact a qualified representative to obtain more information about the appeal resolution.

#### **External Review**

You or your representative have the right to file a written request with ICHIA for an external grievance review of your appeal resolution under Indiana law (IC-27-8-28-17). You must submit your request not more than forty-five (45) days after you are notified of the resolution. This right includes an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize your life or health; or your ability to reach and maintain maximum function. You are entitled to a standard external grievance review for a grievance not described above. A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter. A covered individual who files an external grievance: 1) shall not be subject to retaliation for exercising the covered individual's right to an external grievance; 2) shall be permitted to utilize the assistance of other individuals, including healthcare providers, attorneys, friends, and family members throughout the review process; 3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and 4) shall cooperate with the independent review organization by: (a) providing any requested medical information; or (b) authorizing the release of necessary medical information; (c) ICHIA will cooperate with an independent review organization by promptly providing any information requested by the independent review organization. If you have the right to an external review of a grievance under Medicare, you may not request an external review of the same grievance.

**If you have questions or wish to file a grievance or an appeal, please contact us at:**

ICHIA  
Attn: Appeals  
P.O. Box 33669  
Indianapolis, IN 46203-0669  
[www.ichia.org](http://www.ichia.org)  
1-800-552-7921

## **COORDINATION OF BENEFITS - ICHIA Coordinates Benefits with Medicare**

This provision is used when you are eligible for payment of claims under Medicare.

If you have **Medicare Coverage**, Medicare is primary to ICHIA and the benefits you are entitled to receive from ICHIA will be reduced by the amount Medicare would pay.

You must first use the Medicare benefits to which you are entitled before submitting charges to the ICHIA plan for reimbursement.

Coordination of Benefits assures that your covered expenses will be paid, but that the combined payments of all of the programs do not amount to more than the actual cost of your care. Coordination of Benefits prevents duplicate payments and helps control the cost of healthcare coverage.

## **SUBROGATION AND THIRD PARTY LIABILITY**

Subrogation is similar to Coordinate of Benefits in that your ICHIA benefits are coordinated with another payor. In the case of subrogation, the payor is not a typical health insurance payor, but a payor such as an auto insurance company. Subrogation typically occurs when there is an accident claim and various parties are involved in the reason for the accident and who is responsible for paying the medical claims related to the accident.

If you are injured or become ill through the act of omission of another person, and if benefits are paid under a plan due to that injury or sickness, then to the extent you obtain benefits from the same injury or sickness from another person, their insurer, or your uninsured motorist insurance, ICHIA will be entitled to a refund from such recovery of all benefits ICHIA has paid.

ICHIA may file a lien in your action against a third party and have a lien upon any recovery that you receive, whether a settlement, judgment, or otherwise, and regardless of how such funds are designated. ICHIA shall have a right to recover the full amount of benefits paid under the ICHIA program for the injury or sickness, and that amount shall be deducted first from any recovery made by you. ICHIA will not be responsible for your attorney's fees or other costs.

You must cooperate fully with ICHIA in asserting ICHIA's right to recover. You will be personally liable for reimbursement to ICHIA to the extent of any recovery obtained by you from any third party. If it is necessary for ICHIA to institute legal action against you for failure to repay ICHIA, you will be personally liable for all costs of collection including reasonable attorney's fees.



**IT'S ALL ABOUT MANAGING YOUR HEALTH.  
APS HEALTHCARE PROVIDES  
CARE COORDINATION AND AUTHORIZATION SERVICES.**

**CARE COORDINATION AND AUTHORIZATION SERVICES**

APS Healthcare and Indiana Comprehensive Health Insurance Association (ICHIA) have partnered to provide you with Healthy Together, a free and confidential program offering services to help you manage your health and feel your best. Through APS Healthcare you will receive the following Services:

- Condition Management (Healthy Together)
- Pre-Certification Services
- Care Coordination

**Condition Management (Healthy Together)**

Living with an illness or condition can be a challenge for you and your family. *Healthy Together* offers services to help you manage conditions like Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Diabetes, and Depression so that you can treat them actively and minimize their negative impact on your life.

**The Healthy Together Condition Management** program is free and confidential and is required for all eligible ICHIA members. Eligibility into the program will be determined by APS Healthcare. To see if you qualify for *Healthy Together*, you can either:

**Call APS Healthcare toll free at 1-800-835-1022  
and ask about enrollment in ICHIA Healthy Together**

**- or -**

**An APS Healthcare health coach will contact you by phone to tell you about our services and arrange your enrollment in the ICHIA Healthy Together program.**

**The Healthy Together program provides you with:**

- **A Personal Health Coach**  
Your Health Coach partners with you to help improve your health and quality of life. Your coach will call you regularly to talk about your health, assess your needs, and help you set and meet health goals.
- **Support and Advocacy**  
APS Healthcare will work with your doctors and healthcare providers to support your care and help get you the services you need.
- **Resources**  
APS Healthcare's team of nurses, dieticians and counselors provide guidance on all aspects of your health. APS Healthcare helps you find answers to your health questions and find resources in your community.
- **Information**  
APS Healthcare will provide educational materials and an online library so you can fully understand your condition and take action to improve your health. APS Healthcare also provides help and direction on developing good health habits including:
  - Quitting tobacco
  - Exercising
  - Healthy eating
  - Managing stress
  - Much more

**Additional Services – Care Coordination and Pre-Certification**

In addition to the **ICHIA Healthy Together Program**, APS Healthcare also provides Care Coordination and Precertification Services.

## Care Coordination

If you need help coordinating the healthcare services that you receive, APS Healthcare offers Care Coordination services. The Care Coordinators work with health plans, providers, individuals and their families to help ensure that you receive the healthcare you need. APS Healthcare care coordinators provide:

- Education
- Referrals
- Support transitioning home from the hospital
- Individual treatment planning
- Help navigating the medical system

**APS Healthcare Care Coordinators may be reached at 1-800-835-1022. You may contact us at any time or a care manager may contact you to work with you and your providers to help you receive the care you need.**

## Pre-Certification Services

APS Healthcare is also responsible for ICHIA Pre-Certification Services. When you are planning a hospitalization or have been hospitalized for an emergency, APS Healthcare nurses will work with you and your physician to ensure your healthcare needs are met. Throughout your stay, APS Healthcare nurses keep in contact with your physician, coordinate resources and monitor your progress.

APS Healthcare nurses are also available to answer your questions while in the hospital.

**To obtain Pre-certification services call 1-800-835-1022.**

Pre-certification hours are 8:00 am to 4:00 pm (excluding holidays). After service hours, you may leave a message that will be answered the next business day.

Although many physicians will handle the pre-certification, **it is ultimately your responsibility to ensure pre-certification has been made.** Pre-admission approval must be obtained at least **seven business days before a planned admission** and within **48 hours after a maternity or emergency admission** on a weekday, within 72 hours after an admission on a weekend or on a legal holiday, or as soon as reasonably possible after that.

**Pre-certification is necessary for admission to a hospital and a skilled nursing facility as well as any other “inpatient” admission. Failure to precertify will be subject to penalties shown in the following schedule:**

Plan 1      Reduction by 50% of charges that would have been paid if pre-certification had been  
Plan 1 Rx    obtained (less the applicable deductible).

Plan 2      Benefits reduced by \$300 for all unreviewed days combined. Room and board will not be  
Plan 2 Rx    covered for days deemed NOT medically necessary.

Plan 3      Benefits reduced by \$300 for all unreviewed days combined. Room and board will not be  
Plan 3 Rx    covered for days deemed NOT medically necessary.

Plan 4      Reduction by 50% of charges that would have been paid if pre-certification had been  
Plan 5      obtained (less the applicable deductible).

**When pre-certifying an admission, be prepared to give the following information:**

1. Enrollee name and policy number
2. Provider name and telephone number
3. Facility name and date of planned admission
4. Type of procedure to be performed

The preadmission certification process may be initiated by you, your representative, your provider or a facility representative. Once the preadmission certification has taken place, you, your provider, and the facility will

receive written notice within 24 hours of the pre-certification decision and the approved number of hospital days. Precertification approval does not mean coverage approval (eg., if coverage terminates prior to service date or for non-payment of premium). Coverage approval is based on the terms and conditions described in the ICHIA policy. Contact customer service to verify eligibility and benefits.

Share preadmission certification information from this guide with your representative or other responsible person who could contact ICHIA and arrange for your medical care in the event you are unable to do so yourself.

ICHIA's utilization management program will assess the care being provided and may discuss less costly alternative care with your provider. At the enrollee's option, benefits for this type of less costly alternative care will be provided even if the ICHIA healthcare plan does not specifically provide this type of care.



**YOU HAVE A PREFERRED NETWORK OF  
DOCTORS AND HOSPITALS.  
THE ANTHEM PPO DELIVERS YOUR CARE.**

### **PREFERRED NETWORK OF DOCTORS AND HOSPITALS**

Anthem provides ICHIA a Preferred Provider Organization (PPO) of doctors and hospitals for members which represents a full range of medical specialties and includes hundreds of specialists across Indiana to provide the best medical care available. ICHIA is under the Blue Access Network of Anthem.

To search for a provider in the network you can:

**Go On-Line to [www.ichia.org](http://www.ichia.org), Select the Provider Network Menu Option, then select the Go To Anthem Network Website Link.**

**Once on the Anthem Website, choose Indiana and hit next, then choose your PPO Plan – It is the Blue Access PPO.**

**Call Toll Free at 1-800-552-7921 / Local in Indianapolis 317-614-2133**

**Write To:**

**ICHIA**

**Attn: Customer Service**

**P.O. Box 33009, Indianapolis, IN 46203-0009**

**Visit our Administrator Office:**

**ACS Health Care Solutions (ACS)**

**4550 Victory Lane, Indianapolis, IN 46203**

**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.**

You have increased benefits if you obtain your health services from a doctor, hospital, pharmacy or other provider enrolled with Anthem PPO. Be sure to ask your provider if they are an Anthem provider. You will have to pay more for your medical services out of your pocket if your provider is not currently enrolled or does not agree to enroll with Anthem. Anthem has a very extensive provider network throughout Indiana.

ICHIA also provides you with a secondary PPO Network when you are traveling outside of the Anthem service area. Anthem is always your primary PPO. The secondary network provides access to hospitals and physician discounts outside of Indiana, Kentucky, and Ohio that have agreed to accept discounts on services rendered. You have received a travel and a primary ICHIA ID card. The travel card is the one you would use when you receive care outside of the tri-state area. The secondary network not only provides you with broader access to care, it also reduces your out-of-pocket costs. Services received from non-Anthem providers are still subject to a higher coinsurance amount as described in your benefits.

**Make sure to tell your provider of medical services that you are covered by ICHIA and show your Primary Network ID card or your Travel ID card (if you are outside of IN, KY, and OH) at the time of service.**



**YOU HAVE A PHARMACY SERVICE WHERE YOU  
GET YOUR PRESCRIPTION DRUGS.  
MEDCO IS THE PROVIDER OF PHARMACY SERVICE.**

### **PHARMACY SERVICES**

Medco provides the Pharmacy Benefit Management Services and is where members should go for prescription drugs. Members have access to a nationwide network of pharmacies. Through the Medco pharmacies, members will benefit from negotiated discounts on prescription drugs upon presenting their Medco pharmacy card. The Medco pharmacy deductibles differ by plan.

With the Medco service, you'll have access to:

- Convenient mail-order services through the Medco Pharmacy. You'll be able to have up to a 90-day supply of long-term medication delivered directly to you for one mail-order co-payment. Long-term medications are those taken to treat ongoing conditions, such as high blood pressure, high cholesterol, or diabetes.
- **A large network of participating retail pharmacies.** Your prescription drug benefit gives you access to nearly 60,000 retail pharmacies nationwide, including most major drug stores.
- **Helpful resources on Medco's website, [www.medco.com](http://www.medco.com),** including the ability to order mail-order refills, check order status, compare medication costs, request order forms and envelopes and access useful health and benefit information.
- **Medco Member Services representatives, available 24 hours a day, 7 days a week** (except Thanksgiving and Christmas) to assist with questions about your benefit or orders.
- **Medco specialist pharmacists,** who have expertise in the medications used to treat a single condition such as high blood pressure, asthma, diabetes, or cancer. Specialist pharmacists can answer your questions about how your medications work with each other and how to make them work best for you. Since they know how your plan works, specialist pharmacists can also advise you on potentially reducing your medication costs.

**For Questions about Your Pharmacy Benefits:  
Go on-line to [www.medco.com](http://www.medco.com) – website  
Call Toll Free at 1-877-841-5249**



**This brochure is ONLY a summary of benefits. It is NOT part of the ICHIA Policy Member Handbook.**

**The Policy is available upon request by calling  
Toll Free At 1-800-552-7921 or Local in Indianapolis 317-614-2133  
or you can download the Policy from [www.ichia.org](http://www.ichia.org). The Policy includes more detailed information  
about ICHIA.**

**In the event of a conflict between the information in this brochure and your ICHIA Policy, the terms  
of your Policy will prevail. ICHIA has the right to cancel or terminate your coverage based on the  
provisions described in your Policy**



**1-800-552-7921**  
**[www.ichia.org](http://www.ichia.org)**