HOW TO CONTACT US

ON THE WEB:
www.HIPIOWA.com

BY PHONE:
1.877.793.6880

BY FAX:
1.620-792-0535

VIA MAIL:
HIPIOWA
P.O. Box 1090
Great Bend, KS 67530

ADMINISTERED BY:
Benefit Management, Inc (BMI)

GENERAL ELIGIBILITY REQUIREMENTS

Coverage is available to persons who meet the following general requirements:

1. You must also meet one of the Eligibility Categories listed below.

2. If you are applying under Medical Eligibility, or Medical Condition Eligibility, You must be a resident of the Sate of Iowa – "resident" means a person who has been legally domiciled in the state of Iowa for a period of at least 60 days for purposes other than obtaining insurance. Domicile denotes a person's permanent home and place of habitation. You mist attach evidence of residency with this application.

MEDICAL ELIGIBILITY (At least one of the following must apply to be considered under the Medical Eligibility guidelines)

a. A notice of rejection of health insurance coverage within the last nine months.

b. A notice of health insurance benefit reduction or limitation which substantially reduces benefits compared to benefits available to others such as a rider which excludes or modifies benefits for a condition.

c. A notice of refusal to issue insurance except at a rate exceeding the plan rate of a comparable HIPIOWA plan.

MEDICAL CONDITION

If you have been a legal resident of the State of Iowa for the past 60 days and you suffer from one of the following, you are eligible under the Medical Condition.

- Acquired Immune Deficiency Syndrome (AIDS)
- Angina Pectoris
- Arteriosclerosis Obliterans
- Artificial Heart Valve
- Ascite
- Cardiomyopathy
- Chemical Dependency
- Cirrhosis of the Liver
- Coronary Insufficiency

- Coronary Occlusion
- Cystic Fibrosis
- Dermatomyositis
- Friedrich's Disease
- Huntington's Disease
- Hydrocephalus
- Intermittent Claudication
- Juvenile Diabetes
- Kidney Failure requiring dialysis
- Lead Poisoning with Cerebral Involvement
- Leukemia
- Lupus
- Malignant Tumor (if treated or has occurred within last four years)
- Metastatic Cancer
- Motor or Sensory Aphasia
- Multiple or Disseminated Sclerosis
- Muscular Atrophy or Dystrophy
- Myasthenia Gravis
- Myotonia
- Open Heart Surgery
- Paraplegia or Quadriplegia
- Parkinson's Disease
- Peripheral Arteriosclerosis (if treatment within last three years)
- Polyarteritis (periarteritis nodosa)
- Postero-lateraol Sclerosis
- Psychotic Disorders
- Silicosis
- Splenic Anemia (True Banti's Syndrome)
- Still's Disease
- Stroke
- Syringomyelia Tabes Dorsalis (locomotor ataxia)
- Topectomy and Lobotomy
- Wilson's Disease

FEDERAL ELIGIBILITY

a. HIPAA Eligible Individual--You must be defined as an "Eligible Individual" according to the Health Insurance Portability and Accountability Act, meaning that you:

    1. Must have had 18 months or more of creditable coverage without a break of 63 full days prior to applying for this plan;

    2. Must have had the most recent prior creditable coverage under a group health plan, governmental plan or church plan (or under health insurance coverage offered in connection with such a plan);

    3. May not be eligible for a group health plan;

    4. May not be eligible for Medicare or Medicaid;

5. Must not have lost the most recent coverage because of fraud or non-payment of premiums;

6. If offered COBRA or a similar state program, must elect and exhaust such coverage

NOT ELIGIBLE FOR HIPIOWA COVERAGE

You are not eligible if you meet any of the criteria listed below:

1. You are not a resident of the State of Iowa.

2. You have terminated coverage in HIPIOWA within the last 12 months, unless you can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums; (This does not apply to HIPAA Eligible or TAA Eligible Individuals)

3. You are an inmate of a public institution; (This does not apply to HIPAA Eligible)

4. You have been paid the maximum allowable benefits payable under this program: or

5. You are eligible for a group plan through an employer; or

6. You are eligible for public programs for which the individual premiums are paid for or reimbursed under any government sponsored program or by any government or health care provider.

7. You are eligible for health care benefits under Chapter 249A of the Iowa Code (Medicaid).

HOW TO APPLY TO HIPIOWA

MEDICAL ELIGIBILITY

- If you have been rejected for coverage by an insurance carrier within the last nine months because of health status, you must attach a copy of the rejection notice provided by that carrier.
- If you have received a notice of a health insurance benefit reduction or limitation which substantially reduces benefits compared to benefits available to others, such as a rider which excludes or modifies benefits for a condition, you must attach a copy of the notice provided by that carrier.
- If you have received a notice of refusal to issue insurance except at a rate exceeding the plan rate of a comparable ICHA plan, you must attach a copy of the notice.

MEDICAL CONDITION

- If you have one of the listed health conditions, check all that apply. Must send documentation of health condition from health care provider.

FEDERAL ELIGIBILITY

- If you qualify under the federal eligibility guidelines, you will need to provide a certificate of coverage with the application or as soon as you receive it from your prior carrier(s). If you do not have a certificate of coverage, you may provide other documentation that demonstrates prior coverage beginning **and** ending dates.

Applications postmarked on or before the 20th day of the month will be effective on the first day of the following month.

Applications postmarked after the 20th day of the month will be effective on the first day of the second month following receipt.

Under limited circumstances, an ICHA applicant may choose to have the effective date of coverage retroactive to an earlier date. In order for this opportunity to apply, the applicant must first apply for coverage and be rejected by a health insurance carrier licensed in the State of Iowa. If the applicant then applies to ICHA no later than the end of the full calendar month following the date of original application to the health carrier, the ICHA applicant may choose the first of the month of the ICHA application as the effective date for coverage.

Once your application is approved, we will send you an identification card, insurance policy and a provider directory. The insurance policy provides specific details of your plan's benefits and the procedures you need to follow in order to get the maximum benefits to which you are entitled.

PLAN OPTIONS

HIPIOWA offers five comprehensive preferred provider plans to choose from as well as a Medicare carveout plan.

- PLAN E is a Medicare eligible plan for persons **under** 65 that are enrolled in Medicare. The plan pays secondary to Medicare and has an annual deductible of $1000. If you are eligible for Medicare because you have reached age 65, you are not eligible for this or any other HIPIOWA plan.

- PLANS B, C, D, F AND G are preferred provider plans. These plans give you the option of choosing any provider but pay at a higher percentage of allowed charges if you choose a provider who is part of the Midlands Choice Network. They offer a $1,000, $1,500, $2,500, $5,000 and $10,000 deductible. These plans are not available to Medicare eligible enrollees.

Check with your medical providers for their participation in the Midlands Choice Network or call Midlands Choice at 1.800.605.8259 prompt #5, to verify if your health care provider participates in the network. You can also review the Midlands Choice Provider network through

the HIPIOWA web page @ www.HIPIOWA.com. A copy of the Midlands Choice Provider directory is also available on request. (All plan enrollees receive a directory with their medical plan contract document.)

- A Pharmacy Benefit is included on all preferred provider plans and gives you access to a nationwide network of pharmacies. By using the pharmacy network you will benefit from negotiated discounts on prescription drugs (upon presentation of your identification card). All drugs, supplies, medicines and pharmacy services must be obtained at a network pharmacy. Pharmacy services for Plans F and G are subject to a separate pharmacy deductible. Pharmacy services for Plans A, B and C are not subject to a separate pharmacy deductible or the annual deductible, instead they require a per prescription copayment. The pharmacy benefit has an out-of-pocket expense limit separate from the medical out-of-pocket expense limit. **Please Note:** There is **no** pharmacy benefit for Plan E, the Medicare Carveout Plan.

SUMMARY OF BENEFITS

The following pages are a brief summary of your Plan benefits. Benefits are subject to the full description, provisions, limitations and exclusions set out in the HIPIOWA Plan Policy, which is a complete Plan contract issued to You at the time of Your enrollment. Plan Policy documents are available for review on the HIPIOWA web site and are also available upon request to HIPIOWA. In the event of a discrepancy between this summary and the HIPIOWA Plan Policy, the HIPIOWA Plan Policy will govern.

HIPIOWA

Iowa Comprehensive
Health Association

APPLICATION FOR COVERAGE

SECTION I: PLAN INFORMATION

Please select your Plan Deductible. Changing plans can only be done effective January 1st each year. Once your Plan is selected, you may only change to a higher deductible Plan.

Plans

- ☐ E - $1,000 Deductible - **Medicare Only**
- ☐ B - $1,000 Deductible
- ☐ C - $1,500 Deductible
- ☐ D - $2,500 Deductible
- ☐ F - $5,000 Deductible
- ☐ G - $10,000 Deductible

SECTION II: APPLICANT INFORMATION

Name & Personal Information

Last Name:_____ First Name:_____ MI:_____

Soc. Sec. No.:_____ DOB(mm/dd/yy):_____ Age:____☐ Male ☐ Female

Custodial Parent/Guardian Name, if applicant is a minor or not legally competent:

_____

Address & Phone

Street Address (required):_____

City:_____ State:_____County:_____ Zip Code:_____

P.O. Box (optional):_____City:_____ State:_____ Zip Code:_____

Home Phone:_____Business Phone:_____

Billing Address & Name of entity or person responsible for payment, if different from above:

_____

Residency. "Resident" means a person who has been legally domiciled in this state **for a period of at least 60 days** for purposes other than obtaining insurance.

I have been a resident of Iowa continuously since:_____. You must attach one of the following as proof of residency with this application:

(a) A bill in your name from any public utility at your dwelling in the State of Iowa;
(b) Receipts for rent, mortgage or lease payments for your dwelling in Iowa;
(c) An Iowa driver's license or state identification card;
(d) Proof of registration and payment in Iowa of taxes and fees on motor vehicles;
(e) A voter registration card; or
(f) A copy of your State of Iowa Tax Return.

SECTION III: ELIGIBILITY

A. Eligibility Requirements

I certify, as indicated below, that I am eligible for coverage because:

☐ 1. **Federal Eligibility.**

a. HIPAA Eligible Individual**. (All of the following must apply to be considered under the Federal Eligibility guidelines)**. Please provide a copy of your Certificate of Creditable Coverage or other proof of such coverage.

I am a current resident of the State of Iowa and all of the following apply:

- ☐ I have had 18 months of continuous creditable coverage during which I have not had a break in coverage of 63 or more complete days in a row, at least the last day of which was under a group health plan.
- ☐ I was not terminated based upon nonpayment of premiums or fraud in respect to my most recent coverage.
- ☐ I have used up any COBRA or state continuation of coverage for which I was eligible.
- ☐ I am not eligible for Medicare, Medicaid or a group health plan.
- ☐ I do not have other health insurance coverage.

☐ 2. **Medical Eligibility.** (At least **one** of the below must apply to be considered under the Medical Eligibility guidelines. **INSURANCE COMPANY NOTICE OF REJECTION OR TERMINATION OF HEALTH INSURANCE MUST BE ATTACHED.**)

I am a legal resident of the State of Iowa for the past 60 days and at least **one** of the below applies:

- ☐ A notice of rejection of health insurance coverage within the last nine months.
- ☐ A notice of health insurance benefit reduction or limitation which substantially reduces benefits compared to benefits available to others such as a rider which excludes or modifies benefits for a condition.
- ☐ A notice of refusal to issue insurance except at a rate exceeding the plan rate of a comparable ICHA plan.

☐ 3. **Medical Condition Eligibility.** I am a legal resident of the State of Iowa for the past 60 days and suffer from the below listed health condition(s). **Please check all that apply and send documentation from your health care provider.**

❑ Acquired Immune Deficiency Syndrome (AIDS)	❑ Kidney Failure requiring dialysis	❑ Polyarteritis (periarteritis nodosa)
❑ Angina Pectoris	❑ Lead Poisoning with Cerebral Involvement	❑ Postero-lateraol Sclerosis
❑ Arteriosclerosis Obliterans	❑ Leukemia	❑ Psychotic Disorders
❑ Artificial Heart Valve	❑ Lupus	❑ Silicosis
❑ Ascite	❑ Malignant Tumor (if treated or has occurred within last four years)	❑ Splenic Anemia (True Banti's Syndrome)
❑ Cardiomyopathy	❑ Metastatic Cancer	❑ Still's Disease
❑ Chemical Dependency	❑ Motor or Sensory Aphasia	❑ Stroke
❑ Cirrhosis of the Liver	❑ Multiple or Disseminated Sclerosis	❑ Syringomyelia Tabes Dorsalis (locomotor ataxia)
❑ Coronary Insufficiency	❑ Muscular Atrophy or Dystrophy	❑ Topectomy and Lobotomy
❑ Coronary Occlusion	❑ Myasthenia Gravis	❑ Wilson's Disease
❑ Cystic Fibrosis	❑ Myotonia	
❑ Dermatomyositis	❑ Open Heart Surgery	
❑ Friedrich's Disease	❑ Paraplegia or Quadriplegia	
❑ Huntington's Disease	❑ Parkinson's Disease	
❑ Hydrocephalus	❑ Peripheral Arteriosclerosis (if treatment within last three years)	
❑ Intermittent Claudication		
❑ Juvenile Diabetes		

NO PERSON IS ELIGIBLE FOR COVERAGE IF ONE OF THE FOLLOWING APPLIES:

1. Residency requirements are not met.
2. The person is eligible for health care benefits under Chapter 249A of the Iowa Code (Medicaid).
3. The person has terminated coverage with ICHA within the last 12 months (this requirement does not apply to federally eligible individuals).

4. The person is an inmate of a public institution.
5. The person is eligible for public programs for which the individual premiums are paid for or reimbursed under any government sponsored program or by any government agency or care provider.
6. The person has already received the maximum allowable benefits payable under this program.
7. The person is or becomes eligible for group coverage.
8. The person is eligible to elect COBRA or state continuation coverage.

B. Other Eligibility Information

1. Have you ever been enrolled in ICHA? Yes ☐ No ☐

2. For persons applying for ICHA Plan A ($1,000 Deductible-Medicare Only), I understand that this plan is designed for persons enrolled in Parts A and B of the Federal Medicare Program. My Medicare health insurance number is _____.
   I additionally understand that if I am not enrolled in Part B of the Federal Medicare Program, the amount that is payable under ICHA Plan A will be calculated as if I were enrolled in Medicare Part B.

3. Medicare Eligibility
   Are you currently eligible for Medicare based upon age? Yes ☐ No ☐
   Are you currently eligible for Medicare due to disability? Yes ☐ No ☐

SECTION IV: OTHER COVERAGE

This coverage will pay secondary to any other coverage unless pre-empted by federal law.

1. Do you have any other medical or hospital insurance? (Please list on separate page if additional space is necessary.)
   ☐ Yes ☐ No Medical Assistance (Medicaid/Title 19).
   ☐ Yes ☐ No Aid to Families with Dependent Children.
   ☐ Yes ☐ No Supplemental Security Income.
   ☐ Yes ☐ No Iowa Basic or Standard Coverage.

   Other Coverage 1:

   _____
   (Last Name) (First Name) (MI) (Description of Coverage - Indiv. or Group)

   _____
   (Insurance Co. Name & Phone No.) (Policy No.)

   Other Coverage 2:

   _____
   (Last Name) (First Name) (MI) (Description of Coverage - Indiv. or Group)

   _____
   (Insurance Co. Name & Phone No.) (Policy No.)

2. Do you intend to allow to lapse or otherwise terminate your present policy and replace it with ICHA coverage? ☐ Yes ☐ No If yes, dated terminated: _____.

SECTION V: PREEXISTING CONDITIONS

ICHA plans have a six-month waiting period for preexisting conditions. This means that preexisting conditions will not be covered until the ICHA policy has been in force for six months. Preexisting conditions are conditions which medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for shortening the preexisting condition waiting period, please complete the following information **and attach your Certificate of Coverage from your current or prior carrier.** If you do not have a Certificate of Coverage, you may provide other evidence (including a telephone call from the plan or issuer) that demonstrates prior coverage beginning and ending dates.

1. Please list below your current or prior coverage information:

   _____
   Name & Telephone No. of Carrier [Insurance Company])

   _____
   (Name & ID No. of Subscriber [Contract Holder])

   Date coverage began:_____Date coverage ended:_____

   Per Indiv. Deductible Amount $_____Out-of-pocket Max. Amount $_____

   Family Deductible Amount $_____Out-of-pocket Max. Amount $_____

   Type of Coverage: ☐ Individual ☐ Group ☐ Basic or Standard Coverage
   Type of Benefits (check all that apply): ☐ Medical ☐ Hospital Only ☐ Accident Only
   ☐ Prescription Drug ☐ Dental Vision

2. Do you intend to continue this other coverage if you are accepted for coverage by ICHA?
   ☐ Yes ☐ No If no, you must contact your insurance company to cancel.

The preexisting condition waiting period will be reduced or waived in the following circumstances:

- Federally defined eligible individuals. We will waive the preexisting condition wait for any person who is eligible for such waiver under the standards of the Federal Health Insurance Portability and Accountability Act. This includes persons who are Federal Trade Act eligible individuals.

- **Basic and Standard Prior Coverage. Applicants transferring to a ICHA policy from a basic or standard health benefit plan under Chapter 513C beginning on or after January 1, 2005, will receive a pre-existing condition waiver.**

- Eligible Newborns with prior creditable coverage. In the case of an eligible individual who, as of the last day of the thirty-one day period beginning with the date of birth, is covered under creditable coverage.

SECTION VI: PREMIUM PAYMENT

[PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:]
[☐ **MONTHLY BANK DRAFT** - 1 month premium due with application.]
(Complete attached Authorization Form and include a VOIDED check.)]
[☐ **QUARTERLY** - 3 months premium due with application.]
[☐ **SEMI-ANNUAL** - 6 months premium due with application.]
[☐ **ANNUAL** - 12 months premium due with application.]

MAKE CHECK PAYABLE TO ICHA

[USE THE RATE TABLE TO DETERMINE YOUR PREMIUM PAYMENT.]

[Premium Rate Table used: _____]

[

PREMIUM AMOUNT (ACCORDING TO YOUR PAYMENT OPTION):
PREMIUM AMOUNT ENCLOSED:

FOR OFFICE USE ONLY	
PREMIUM PAYMENT	CHECK NUMBER

]

EFFECTIVE DATE OF COVERAGE:

NOTE: Approved applications are effective the first of the month as follows:

- Applications postmarked by the 20th day of the month will be effective on the first day of the following month.
- Applications postmarked after the 20th day of the month will be effective on the first day of the second month following receipt.

☐ To select a future effective date, please indicate here (no more than 60 days after the postmarked date): First of (month)_____ (year) _____.

☐ Under limited circumstances, an ICHA applicant may choose to have the effective date of coverage retroactive to an earlier date. In order for this opportunity to apply, the applicant must first apply for coverage and be rejected by a health insurance carrier licensed in the State of Iowa. If the applicant then applies to ICHA no later than the end of the full calendar month following the date of original application to the health carrier, the ICHA applicant may choose the first of the month of the ICHA application as the effective date for coverage.

SECTION VII: NON-TOBACCO DISCOUNT

Do you smoke or use tobacco products or have you smoked or used tobacco products during the 12 months immediately preceding the date of this application. ☐ Yes ☐ No If you answered NO, you are eligible for the Non Tobacco-User Rate.

"Smoke or use tobacco products" means any use of cigarettes, pipes, cigars or any other tobacco products regardless of the number of times, frequency or method of use.

If your tobacco usage status changes, you must notify ICHA immediately. You may also be required by us to re-certify this status in the future.

If it is determined that the status reported is incorrect, we will retroactively collect historical differences in premiums before claims will be paid and the Tobacco-User rate will apply.

SECTION VIII: DISCLOSURE CERTIFICATION

By signing this form, I certify the following:

(a) All of the answers provided are true and complete.

(b) I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under the ICHA coverage and may face other penalties for prosecution and collection.

(c) The ICHA coverage will not be effective until this application has been signed, submitted in full by the applicant, and approved by ICHA. Deposit of premium payment does not guarantee coverage. The payment will be refunded for an applicant who is not eligible for coverage.

(d) I have read the privacy notice at the end of this brochure.

_____

SIGNATURE OF APPLICANT (OR CUSTODIAL PARENT/GUARDIAN IF APPLICANT IS UNDER AGE 18 OR NOT LEGALLY COMPETENT)

DATE: (MONTH / DAY / YEAR)

_____

PRINT APPLICANT'S NAME

SECTION IX: PRODUCER INFORMATION

I/We certify that during an in-person interview with applicant, I/we asked each question exactly as written and recorded the answers provided by the applicant completely and accurately.

☐ Yes ☐ No

Signature of Producer _____ Date _____

Printed Name of Producer _____ Telephone No. _____

Producer's License/ID Number _____

Office Name _____

Office Address _____

MAIL COMPLETED APPLICATION TO:

ICHA
Attention: Enrollment
P.O. Box 1090
Great Bend, KS 67530