

**ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL
("CHIP")**

**COMPREHENSIVE MAJOR MEDICAL
EXPENSE POLICY**

**Administered By:
BlueAdvantage Administrators of Arkansas (Administrator)**

**"CHIP" OUTLINE OF COVERAGE for
for 2003 Trade Adjustment Act Health Coverage Tax Credit
Relating to Policy Form CHIP HCTC- 101 (10/03)**

This Outline of Coverage is not a policy. The complete terms of the CHIP coverage are set forth in the CHIP insurance policy ("Policy") identified in the heading above. This Outline of Coverage provides a brief description of the important features of the Policy offered by CHIP. CHIP is a non-profit legal entity created by the Arkansas General Assembly to provide health insurance coverage to eligible persons. The Policy itself sets forth in detail the rights and obligations of CHIP and Insured Persons under the Policy.

MAJOR MEDICAL EXPENSE COVERAGE (comprehensive health expense coverage): Policies of this category are designed to provide coverage to Insured Persons for major hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care and drugs, subject to any Deductibles, Coinsurance provisions, or other limitations which may be set forth in the Policy. **Inpatient admissions require pre-certification from the Administrator. Failure to pre-certify admissions results in a reduction in benefits. (See page 12 of this Outline of Coverage.)**

DEFINITIONS

Key terms used in the Eligibility Worksheet, Enrollment Forms and this Outline of Coverage are defined below. The Policy contains additional definitions of medical and insurance terms used in the Policy.

Annual Out-of-Pocket Maximum means a dollar amount limit paid by Insured Persons for certain Covered Expenses. After the Annual Out-of-Pocket Maximum is reached, CHIP pays

most In-Network and prescription drug benefits at 100% for the remainder of the year. (See page 11 of this Outline of Coverage.)

Church Plan means a plan established and maintained for its employees (or their beneficiaries) by a church or by an association of churches which is exempt from taxation under Section 501 of the Internal Revenue Code.

Coinsurance means the percentage of Covered Expenses for which an Insured Person is responsible according to the Schedule of Benefits in his or her Policy and applies after he or she first satisfies his or her Deductible requirement.

Covered Expense means an expense that CHIP has agreed to pay under the Policy if medically necessary and not otherwise limited or excluded by the terms, conditions, and limitations of this Policy. Please see the Policy for more information.

Creditable Coverage means coverage of an individual under any of the following:

- Health Insurance Coverage (including coverage provided through a Group Health Plan);
- a Group Health Plan;
- Medicare;
- Coverage through the Arkansas Medical Assistance Program (Medicaid or ARKids);
- Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents);
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health plan offered under Chapter 89 of Title 5, United States Code (the Federal Employees Health Benefit Program);
- a public health plan (any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan);
- a health benefit plan under § 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); and
- a plan offered under the State Children's Health Insurance Program.

Excluded benefits: Creditable Coverage *does not* include the following types of coverage: accident-only, disability income, liability, auto (including auto medical payment), credit-only or workers compensation insurance; on-site clinic plans; dental-only or vision-only plans; long-term care plans; specific disease plans or hospital indemnity plans, when not offered in coordination with a group health plan; supplemental plans such as Medicare supplement, CHAMPUS supplement or hospital supplement plans.

Deductible means the Deductible amount set forth in an Insured Person's Coverage Summary and CHIP I.D. card, which is the amount of Covered Expenses the Insured Person must pay each year from his or her own pocket before CHIP will make payment for Covered Expenses.

Governmental Plan means a plan established or maintained for its employees by the Government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "Governmental Plan" also includes any plan to which the Railroad Retirement Act of 1935, or 1937 (45 U.S.C. 231 et seq.) applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act (22 U.S.C. 288 et seq.).

Group Health Plan means a plan established or maintained by an employer or by an employee organization, or by both, that provides for medical care to employees or their dependents, either directly or through insurance, reimbursement or otherwise.

Health Insurance or Health Insurance Coverage means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, hospital or medical service corporation, health maintenance organization, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise and includes any excess or stop-loss coverage.

Excluded from definition: Health Insurance *does not* include any types of coverage excluded from the definition of Creditable Coverage, or short-term limited duration policies.

Health Savings Account ("HSA") is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

HSA-Qualified Plan is Health Insurance offered by CHIP that meets the standards of federal law for use with an HSA.

Included Covered Expense is a Covered Expense that counts toward the Annual Out-of-Pocket Maximum and is paid at 100% for the remainder of a calendar year once an Insured Person reaches the Annual Out-of-Pocket Maximum.

In-Network Providers mean hospitals, physicians, or other providers who are paid directly by the Administrator and have agreed to accept the CHIP payment for Covered Expenses as payment in full except for any applicable Deductible and Coinsurance.

Insured Person is a person whose application is accepted by the Administrator and in whose name this Policy is issued and who continues to meet the eligibility requirements included in the Policy.

Out-of-Network Providers are all providers that are not In-Network Providers.

Qualified High Risk Pool is a health insurance risk pool similar to CHIP that offers health insurance coverage to certain individuals leaving the group health insurance market, in accordance with the Health Insurance Portability and Accountability Act of 1996, and that:

- does not place any pre-existing condition exclusions or affiliation periods on health insurance coverage provided to such eligible individuals; and
- provides for premium rates and covered benefits consistent with standards stated in federal law. *See* 45 C.F.R. § 148.128(a)(2)(ii).

WHO IS COVERED BY THIS POLICY?

In 2002, Congress passed a law providing a Health Coverage Tax Credit (HCTC) to certain eligible individuals and their qualifying family members. Under the law, such persons can receive a tax credit equal to 65% of the health care premium paid for the individual and a qualifying spouse or Dependent(s).

In the 2003 legislative session, the Arkansas General Assembly passed a law making it possible for CHIP to offer coverage to such persons, if they meet CHIP eligibility requirements. CHIP issues a separate Policy for each individual who qualifies for coverage based on the application and supporting document(s).

ELIGIBILITY REQUIREMENTS

I. HCTC Qualified Eligible Person and His or Her Qualifying Spouse or Dependents. Individuals eligible for the HCTC who have at least three (3) months of Creditable Coverage¹ without a break in coverage of 63 days or more, and the spouse or Dependents of those individuals, may be eligible for CHIP coverage *without being subject to preexisting condition exclusions* (see page 13 of this Outline of Coverage). These persons must meet the eligibility criteria described below:

¹ Creditable coverage includes most types of health plans, including those offered by an employer, the federal government or a state.

A. HCTC Qualified Eligible Person. In order to be eligible for coverage under the CHIP Policy as a HCTC Qualified Eligible Person, a person:

- (1) MUST HAVE, AS OF THE DATE THE INDIVIDUAL COMPLETES AND SUBMITS AN APPLICATION FOR CHIP COVERAGE, AN AGGREGATE OF AT LEAST THREE (3) MONTHS OF CREDITABLE COVERAGE WITHOUT A BREAK IN SUCH COVERAGE OF SIXTY-THREE (63) DAYS OR MORE;
- (2) must be legally domiciled in Arkansas;
- (3) must present to CHIP a letter or other written notice from the Health Coverage Tax Credit Program that the individual is or may be eligible for the Health Coverage Tax Credit (HCTC);
- (4) must not be incarcerated by a federal state or local authority;
- (5) must not be eligible for coverage for, or enrolled in, Part A or B of Medicare;
- (6) must not be enrolled in:
 - (a) the Arkansas Medical Assistance Program (Medicaid or ARKids);
 - (b) a federal employee health plan;
 - (c) a U.S. military health plan (TRICARE/CHAMPUS);
 - (d) a health plan provided through the person's, or the person's spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or
 - (e) a plan provided through the person's, or the person's spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.

B. HCTC Qualified Eligible Family Member. An individual may be enrolled for coverage as a HCTC Qualified Eligible Family Member if:

- (1) the individual is the spouse or Dependent for federal income tax purposes of a HCTC Qualified Eligible Person;
- (2) the individual is:

- (a) not eligible for coverage for, or enrolled in, Part A or B of Medicare;
- (b) not enrolled in:
 - (i) the Arkansas Medical Assistance Program (Medicaid or ARKids);
 - (ii) a federal employee health plan;
 - (iii) a U.S. military health plan (TRICARE/CHAMPUS);
 - (iv) a health plan provided through the person's, or the person's spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or
 - (v) a plan provided through the person's, or the person's spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan; and
- (3) the HCTC Qualified Eligible Person applies for coverage for the spouse or Dependent at the same time he or she applies for coverage, or within 31 days after the spouse or Dependent Family Member first qualifies for coverage under subsections (1) and (2), above.

II. HCTC Standard Eligible Person and his or her Qualifying Spouse or Dependents.

If a person eligible for HCTC does not have the three months of Creditable Coverage described above, the person and his or her spouse and Dependents still may qualify for CHIP coverage if they meet the following criteria:

A. HCTC Standard Eligible Person. In order to be eligible for coverage under the Policy as a HCTC Standard Eligible Person, a person:

- (1) must be legally domiciled in Arkansas;
- (2) must present to CHIP a letter or other written notice from the Health Coverage Tax Credit Program that the individual is or may be eligible for the Health Coverage Tax Credit (HCTC);
- (3) must not be incarcerated by a federal, state or local authority;
- (4) must not be eligible for coverage for, or enrolled in, Part A or B of Medicare or the Arkansas Medical Assistance Plan (Medicaid and ARKids)

First);

- (5) must not be enrolled in:
- (a) a federal employee health plan;
 - (b) a U.S. military health plan (TRICARE/CHAMPUS);
 - (c) a health plan provided through the person's, or the person's spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or
 - (d) a plan provided through the person's, or the person's spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan;
- (6) must not be enrolled in *or eligible for* any other Health Insurance Coverage, including the coverage described in paragraph (5), above, if the coverage is substantially similar to or more comprehensive than the CHIP policy, except that:
- (i) a person may maintain other coverage for the period of time such person is satisfying any pre-existing condition waiting period under the Policy; and
 - (ii) a person may maintain coverage under this Policy for the period of time such person is satisfying a pre-existing condition waiting period under another Health Insurance Coverage, Group Health Plan, or other coverage intended to replace the Policy;
- (7) must not:
- (a) have previously terminated CHIP coverage unless twelve (12) months have elapsed since the termination of the CHIP coverage;
 - (b) have received benefits under a prior CHIP policy of \$1,000,000 or more in Covered Expenses or benefits of any kind;
 - (c) be a resident of a public institution;
 - (d) fail to pay the required premium under the CHIP Policy; or
 - (e) have premium paid on the person's behalf under any governmental sponsored program or by any government agency or health care

Provider, except premiums paid:

- (i) as advance payment on the Health Coverage Tax Credit; or
- (ii) on behalf of an otherwise qualifying full time employee, or Dependent of such employee, of a government agency or health care provider; and

(8) MUST PROVIDE EVIDENCE TO CHIP'S ADMINISTRATOR:

- (a) of a notice of rejection or refusal by an insurer to issue substantially similar individual Health Insurance Coverage by reason of the existence or history of a medical condition (*a rejection or refusal by a Group Health Plan or by an insurer offering only Excess or Stop Loss Coverage, or contracts, agreements, or other arrangements for reinsurance coverage with respect to the Applicant shall not be sufficient evidence under this subsection*);
- (b) of a refusal by an insurer to issue individual Health Insurance Coverage except at a rate which CHIP determines is substantially in excess of the applicable premium rate under this Policy; or
- (c) that the Applicant was covered under a Qualified High Risk Pool of another state, provided that the coverage terminated no more than 63 days prior to the date CHIP received the Applicant's completed application, and the other state's Qualified High Risk Pool did not terminate the Applicant's coverage due to fraud.

B. HCTC Standard Eligible Family Member. An individual may be enrolled for coverage as a HCTC Standard Eligible Family Member if:

- (1) the individual is the spouse or Dependent for federal income tax purposes of a HCTC Standard Eligible Person;
- (2) the individual is:
 - (a) not eligible for coverage for, or enrolled in, Part A or B of Medicare;
 - (b) not enrolled in:
 - (i) the Arkansas Medical Assistance Program (Medicaid or ARKids);

- (ii) a federal employee health plan;
 - (iii) a U.S. military health plan (TRICARE/CHAMPUS);
 - (iv) a health plan provided through the person's, or the person's spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage; or
 - (v) a plan provided through the person's, or the person's spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan; and
- (3) the HCTC Standard Eligible Person applies for coverage for the spouse or Dependent at the same time he or she applies for coverage, or within 31 days after the spouse or Dependent Family Member first qualifies for coverage under sections (1) and (2), above.

III. Special Rules for Newborn Children. The following rules apply to newborn natural children of Insured Persons:

A. Newborn child of a HCTC Qualified Eligible Person or HCTC Standard Eligible Person. The newborn child will be issued a CHIP Policy providing coverage from the date of birth if:

- (1) the HCTC Standard Eligible Person or HCTC Qualified Eligible Person submits an application on behalf of his/her Newborn Child within thirty-one (31) days of the date of the child's birth;
- (2) the premium for the Newborn's CHIP Policy is paid when the Policy is issued; and
- (3) the newborn child meets the criteria for a HCTC Qualified Eligible Family Member or a HCTC Standard Eligible Family Member (see sections I.B and II.B, above).

B. Newborn child of other Insured Persons. The newborn child of any other Insured Person under the Policy will be issued a CHIP Policy providing coverage from the date of birth if:

- (1) the Insured Person submits an application on behalf of his/her newborn child within thirty-one (31) days of the date of the child's birth;

- (2) the premium for the newborn's CHIP Policy is paid when the Policy is issued;
- (3) the newborn child is not eligible for any other health benefits coverage whether insured, self insured or a governmental program; and
- (4) the newborn child is a resident of the State of Arkansas.

TERMINATION OF COVERAGE

Generally, the coverage under the CHIP Policy shall be terminated at the end of the monthly coverage period for any person who ceases to meet the eligibility requirements or who requests termination. If a HCTC Standard Eligible Person or HCTC Qualified Eligible Person loses eligibility for the Health Coverage Tax Credit, the Policies issued to both him or her *and his or her covered spouse and/or Dependents* will be cancelled.

CHIP may terminate the Policy immediately if an Insured Person dies or Arkansas law requires immediate termination.

BENEFITS

In-Network versus Out-of-Network Providers

CHIP coverage is most effective and advantageous when the Insured Person utilizes the services of In-Network Providers. Reimbursement for services by Out-of-Network Providers generally will be less than payment for the same services when provided by In-Network Providers and could result in substantial additional out-of-pocket expense.

In-Network Providers are paid directly by the Administrator and have agreed to accept the CHIP payment for Covered Expenses as payment in full except for any applicable Deductible and Co-Insurance. On the other hand, when the Insured Person receives services from Out-of-Network Providers, the Insured Person is responsible for all balances when services are rendered and must file a claim with the Administrator to be reimbursed for CHIP's share of the Covered Expenses. The determination of whether a hospital, physician, or other provider is an In-Network Provider or an Out-of-Network Provider is the responsibility of the Administrator. The Administrator can provide a list of In-Network Providers.

The decision about whether to use an In-Network Provider is the sole responsibility of the Insured Person. In-Network Providers are not employees or agents of CHIP or the Administrator. Neither CHIP nor the Administrator makes any representations or guarantees regarding the qualification or experience of any facility or provider with respect to any service. The evaluation of such factors and the decision about whether to use any facility or provider is the sole responsibility of the Insured Person.

Prescription Drugs

Drugs requiring a physician's prescription are covered at the In-Network level of benefits if the drug is a Covered Expense under the Policy. However, Insured Persons have to pay the full cost for their prescriptions when they pick them up at the pharmacy and file claims with CHIP for reimbursement.

IMPORTANT NOTICE. For prescription drugs to be covered, an Insured Person must file a claim for a prescription within six (6) months after filling the prescription. (See section on Claims on page 14 of this Outline of Coverage.)

Satisfying the Calendar Year Deductible

To satisfy the Deductible amount, the Insured Person pays the first \$1,000, \$1,250 (for HSA-Qualified Plans) \$5,000 or \$10,000 in Covered Expenses per year, depending on the level of Deductible chosen on the CHIP application form.

Annual Out-of-Pocket Maximum for Included Covered Expenses

Included Covered Expenses are subject to an Annual Out-of-Pocket Maximum. Generally, Included Covered Expenses are most Covered Expenses for services performed by In-Network Providers and most Covered Expenses for prescription drugs. The Policy will explain which Covered Expenses are Included Covered Expenses. The Annual Out-of-Pocket Maximum is the most an Insured Person will pay for Included Covered Expenses out of his or her own pocket per calendar year. Current Annual Out-of-Pocket Maximums for CHIP plans are as follows:

<u>Deductible</u>	<u>Annual Out-of-Pocket Maximum</u>
\$1,000	\$2,000
\$1,250 (HSA)	\$3,250
\$5,000	\$10,000
\$10,000	\$20,000

IMPORTANT NOTICE: Covered Expenses provided by an Out-of-Network Provider **DO NOT COUNT** towards the Annual Out-of-Pocket Maximum. However, an Insured Person will receive a higher level of benefits for most out-of-network care once he or she reaches the Annual Out-of-Pocket Maximum. Please see the Policy for more information.

Maximum Lifetime Benefit

Maximum lifetime benefits under the CHIP Policy shall not exceed \$1,000,000 per Insured Person.

Covered Services and Pre-Certification

Services covered under the Policy include the following, subject to limitations and exclusions included in the Policy:

- Daily Semi-Private Hospital Room and Board
- Miscellaneous Hospital Services
- Skilled Nursing Facility Care
- Diagnostic X-ray and Lab
- Outpatient Care
- Surgical Services
- Anesthesia Services
- Office Visits
- Durable Medical Equipment, Supplies and Appliances
- Drugs Requiring a Physician's Prescription
- Home Health Care
- Diabetes Self-Management Training
- Maternity Care

IMPORTANT: All inpatient admissions (into a hospital or other facility) require pre-certification. To pre-certify benefits, the hospital, provider or Insured Person contacts the Administrator, usually by phone. The Administrator evaluates the medical necessity and appropriateness of the procedure, service, supply, drug, or article and provides written verification, or Pre-certification, to both the hospital or provider and the Insured Person.

FAILURE TO PRE-CERTIFY MAY RESULT IN A \$500 REDUCTION IN BENEFITS.

Limitations

Limitations under the Policy include the following. (See the Policy for a full discussion of its limitations.)

- Expenses for diagnosis and treatment of chemical or drug dependency, and for drugs prescribed to treat chemical or drug dependency, are limited to maximum annual Covered Expenses of \$4,000 and may have other limitations. Please check the Policy for more information on this benefit.
- Expenses for diagnosis and treatment of mental or nervous disorders, and for drugs prescribed to treat mental or nervous disorders, are limited to maximum annual Covered Expenses of \$4,000 and may have other limitations. Please check the Policy for more information on this benefit.
- Home Health Care is covered up to 270 visits by an RN or LPN per calendar year.

- Diabetes Self-Management Training is limited to one lifetime benefit as prescribed by a physician.
- Care in a Skilled Nursing Facility is covered up to one hundred twenty (120) days per calendar year, certified sixty (60) days at a time.

Exclusions

Exclusions under the Policy include the following. (See the Policy for a full discussion of its exclusions.)

- Illness or injuries caused by war, dentistry (except for oral surgery), routine physical examinations, eye refractions, eyeglasses or hearing aids, cosmetic surgery and services, supplies, drugs or articles that are not medically necessary.
- **Pre-existing Condition Exclusions.** HCTC Qualified Eligible Persons and their HCTC Qualified Eligible Family Members covered by CHIP are not subject to any pre-existing condition exclusions.

HCTC Standard Eligible Persons and their HCTC Standard Eligible Family Members covered by CHIP are subject to pre-existing condition exclusions, unless such person is eligible for and purchases the pre-existing condition waiver described below.

If an Insured Person is subject to the pre-existing condition exclusion, coverage under this Policy will not include as Covered Expenses those incurred during the first six (6) months following the effective date of coverage as to any condition if: (1) the condition has manifested itself within the six (6) month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment; or (2) medical advice, care or treatment was recommended or received within the six (6) month period immediately preceding the effective date of the coverage. For example, if a HCTC Standard Eligible Person or HCTC Standard Eligible Family Member knows, or should know based on symptoms, that the person has a condition such as pregnancy or an illness when applying for coverage, then coverage for maternity care, or for care related to the illness, is excluded during the person's first six (6) months of coverage, unless otherwise required by law.

- **Conditional Waiver of Pre-existing Condition Exclusion.** A HCTC Standard Eligible Person may purchase a conditional waiver of the pre-existing condition exclusion for himself or herself and each of his or her HCTC Standard Eligible Family Members, if such persons: (1) have satisfied similar exclusions and had six months of coverage under any prior individual Health Insurance Coverage that was involuntarily terminated for reasons other than non-payment of premium or fraud; (2) have applied for CHIP coverage not later than thirty (30) days following the involuntary termination.

The cost of the waiver per Policy is a surcharge of 10% of the individual's otherwise applicable annual premium for as long as that individual's coverage under CHIP remains in effect, or sixty (60) months, whichever is less. The surcharge shall be pro-rated and charged monthly.

CLAIMS

Filing a Claim

To receive prescription drug benefits under this Policy, you must pay the entire cost of the drug at the time of purchase and submit a claim for reimbursement of CHIP's share of Covered Expenses.

In most other cases, you do not have to file a claim for benefits since most hospitals and providers will bill CHIP directly.

Time Limitation in Which to File a Claim

When you file claims with CHIP yourself for drugs requiring a physician's prescription or in other circumstances, you must submit an itemized bill for the services, supplies, drugs, articles or treatment not later than six (6) months from the date you receive such services, supplies, drugs, or articles or treatment.