

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

**COMPREHENSIVE MAJOR MEDICAL  
EXPENSE POLICY**

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

**"CHIP" OUTLINE OF COVERAGE for  
for "Federally Eligible Individuals" and "Resident Eligible Persons"  
Relating to Policy Form CHIP 201 (3/04)**

This Outline of Coverage is not a policy. The complete terms of the CHIP coverage are set forth in the CHIP insurance policy identified in the heading above ("Policy"). 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 8 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 7 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 Federally Eligible Individuals and:

- does not place any pre-existing condition exclusions or affiliation periods on health insurance coverage provided to Federally 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?**

**Federally Eligible Individuals:** Under federal law, persons who are currently Arkansas residents and who have had health insurance coverage for at least 18 months without breaks in coverage of 63 days or more may qualify for CHIP coverage that does not exclude pre-existing conditions. These persons are called “Federally Eligible Individuals” in the Policy.

**Resident Eligible Persons:** Persons who do not qualify as Federally Eligible Individuals may still qualify for CHIP coverage as Resident Eligible Persons if they are currently residents of Arkansas, have been residents of Arkansas for at least 90 days and have been rejected for coverage in the individual health insurance market because of a health condition, or refused individual health insurance except at rates substantially higher than CHIP’s rates. Persons also may qualify as Resident Eligible Persons if they recently were covered in another state by a Qualified High Risk Pool.

Eligibility requirements for Federally Eligible Individuals and Resident Eligible Persons are set forth in full below.

### **I. Federally Eligible Individuals**

To enroll in CHIP as a “Federally Eligible Individual,” you must:

1. be a resident of Arkansas;

2. have, as of the date on which you complete your CHIP application, an aggregate of 18 months of Creditable Coverage without a break in coverage of 63 days or more;
3. have been covered most recently by Creditable Coverage offered through a Group Health Plan, a Governmental Plan, or a Church Plan (or Health Insurance Coverage offered in connection with any such plans);
4. not be currently covered by, *or eligible for*, coverage under:
  - a. a Group Health Plan;
  - b. Part A or Part B of Medicare; or
  - c. the Arkansas Medical Assistance Program (Medicaid or ARKids);
5. not have had your most recent Creditable Coverage terminated based upon a factor related to nonpayment of premiums or fraud;
6. have been offered a continuation of coverage option under COBRA or a similar state law continuation provision and, if you elected such coverage, have exhausted such coverage;
7. not currently have other health insurance coverage;
8. not previously have received CHIP benefits equaling \$1,000,000 or more;

## **II. Resident Eligible Persons**

To enroll in CHIP as a “Resident Eligible Person,” you must:

1. have been a resident of Arkansas for *at least 90 days* and present evidence to the Administrator of:
    - a. 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; or
    - b. a refusal by an insurer to issue *individual* health insurance coverage except at a rate substantially in excess of (at least 50% greater than) the applicable premium rate under a comparable CHIP Policy;
- or
2. have been a resident of Arkansas for *at least 30 days* and present evidence to the Administrator that you were covered under a Qualified High Risk Pool of another

state, if such coverage ended no more than 63 days before you complete your CHIP application and was not terminated for reasons of fraud;

and

3. not be enrolled in or eligible for coverage through a Group Health Plan, Part A or B of Medicare or the Arkansas Medical Assistance Program (Medicaid and ARKids);
4. not be enrolled in any other Health Insurance Coverage, *except that* if you have provided the Administrator evidence required by either paragraph 1 or 2, and 3, above, and meet the requirements of paragraphs 5-8, below, you may maintain any existing health insurance coverage while you are satisfying the pre-existing condition waiting period under the CHIP Policy;
5. not have previously terminated CHIP coverage in the twelve (12) months prior to the date the individual applies for CHIP coverage;
6. not have previously received CHIP benefits equaling \$1,000,000 or more;
7. not be a resident of a public institution; and
8. not have premium paid on the individual's behalf under any governmental sponsored program or by any government agency or health care provider, except premiums paid on behalf of an otherwise qualifying full time employee, or dependent of such employee, of a government agency or health care provider.

### **III. Special Rules for Newborn Children**

CHIP does not offer family plans and does not offer coverage based on a person's status as a dependent of a Federally Eligible Individual or a Resident Eligible Person, except as provided in this section. If a person is insured under CHIP as a Federally Eligible Individual or a Resident Eligible Person at the time a newborn child is born to the person, the child 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 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 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. 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 Claims on Page 10.)

### **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 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.** Federally Eligible Individuals are not subject to any pre-existing condition exclusions.

Resident Eligible Persons are subject to pre-existing condition exclusions, unless such person is eligible for and purchases the pre-existing condition waiver described below.

If a Resident Eligible 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 Resident Eligible Person 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 Resident Eligible Person may purchase a conditional waiver of the pre-existing condition exclusion if he or she (1) has 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; and (2) has 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.**