

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

**Policy Form – 2003 Trade Adjustment Act Health Coverage Tax Credit**

Administered by

**BlueAdvantage  
Administrators**

320 W. Capitol Avenue, Suite 500•  
Little Rock, Arkansas 72201

OR

P. O. Box 1460  
Little Rock, AR 72207  
1-800-285-6477

**TABLE OF CONTENTS**

I.	POLICY.....	1
II.	DEFINITIONS .....	2
III.	SCHEDULE OF BENEFITS.....	13
IV.	INFORMATION ABOUT YOUR BENEFITS .....	19
V.	COVERED EXPENSES .....	21
	A. <b>Hospital Care</b> .....	21
	B. <b>Hospital Benefits</b> .....	21
	C. <b>Emergency and Out-of-State Hospital Admission</b> .....	22
	D. <b>Inpatient Care for Chemical and Drug Dependency</b> .....	22
	E. <b>Inpatient Care for Mental and Nervous Disorders</b> .....	22
	F. <b>Emergency Room Care</b> .....	22
	G. <b>Pre-admission Testing</b> .....	23
	H. <b>If Benefits Under This Policy Change</b> .....	23
	I. <b>Skilled Nursing Facility Care</b> .....	23
	J. <b>Home Health Care</b> .....	24
	K. <b>Residential Care for Chemical and Drug Dependency</b> .....	24
	L. <b>Provider Services</b> .....	24
	M. <b>Other Services and Supplies</b> .....	27
VI.	GENERAL LIMITATIONS .....	29
	A. <b>Pre-existing Condition Exclusions</b> .....	29
	B. <b>Subrogation</b> .....	30
	C. <b>Pre-certification: How to Pre-certify</b> .....	31
	D. <b>Chemical and Drug Dependency</b> .....	31
	E. <b>Temporomandibular Joint Services</b> .....	32
	F. <b>Transplantation</b> .....	32
VII.	GENERAL EXCLUSIONS .....	37
VIII.	ELIGIBILITY AND ENROLLMENT .....	49
	A. <b>When Coverage Begins</b> .....	49
	B. <b>Policy Issued to Each Insured Person</b> .....	49
	C. <b>Eligibility for Coverage</b> .....	49
IX.	PREMIUM PAYMENTS.....	55
X.	WHEN THIS COVERAGE ENDS .....	59
XI.	GENERAL PROVISIONS .....	64
	A. <b>Benefits Available From Other Sources</b> .....	64
	B. <b>Determining Continued Medical Necessity</b> .....	69
	C. <b>Alternative Services</b> .....	69
	D. <b>Coordinated Care Services</b> .....	70
	E. <b>You Must Submit Medical Information</b> .....	70
	F. <b>Benefits Are Not Transferable</b> .....	70
	G. <b>When Benefits Are Available</b> .....	70
	H. <b>Submission and Payment of Claims</b> .....	71
	I. <b>We Are Not Responsible for the Quality of Medical Care</b> .....	74
	J. <b>Parties Do Not Lose Their Rights</b> .....	74
XII.	CHANGING THIS POLICY .....	75
XIII.	NOTICES UNDER THIS POLICY .....	75

## I. POLICY

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A. **The Policy.** This Policy consists of this document, your application (which includes the Eligibility Worksheet and the Enrollment Form), Ark. Code Ann § 23-79-501 et seq. and any endorsements. It is the entire understanding between you and the Arkansas Comprehensive Health Insurance Pool (CHIP). In this Policy, the terms “we,” “us” and “our” refer to CHIP. “You,” “your” and “yours” mean the Insured Person. This Policy is administered by a Plan Administrator under a contract with CHIP.

B. **Policy Revisions.** We can change this Policy by giving you thirty (30) days advance notice but we will change it only if we change all policies of the same form. If you qualify, elect and pay an additional premium charge, you may purchase a maternity endorsement covering your pregnancy or a Pre-existing Condition Exclusion Waiver endorsement in order to receive coverage for pre-existing conditions that otherwise may be excluded from coverage under this Policy (see subparagraph A. of SECTION VI. - GENERAL LIMITATIONS).

C. **Other Coverages.** The benefits payable under this Policy for Covered Expenses may be reduced to the extent you have any other coverage for those expenses. This Policy’s Deductible and Coinsurance percentages will be applied after recognition of benefits paid or payable by any other coverage.

D. **In-Patient Admissions Must Be Pre-Certified.** You or your Provider must obtain pre-certification for your admission to a Hospital or other in-patient facility. Failure to pre-certify may result in a \$500 reduction in your benefits. (See subparagraph C. of SECTION VI. – GENERAL LIMITATIONS.)

## II. DEFINITIONS

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The following are definitions of some important terms used in this Policy. Other terms are defined where they are first used in this Policy.

A. **Allowed Charge or Reasonable Charge Means:**

- (1) the amount deemed by the ADMINISTRATOR, in its sole discretion, to be reasonable. The BlueAdvantage Administrators' customary allowance is the basic Allowed or Reasonable Charge. However, this charge may vary, given the facts of the case and the opinion of the ADMINISTRATOR'S medical director.
- (2) Notwithstanding any other provisions of this Policy, at the option of the ADMINISTRATOR, the Allowed Charge for an organ transplant, including any Allowed Charge for the procurement of the organ, Hospital services, Provider services and associated costs, including the cost of complications arising from the original procedure, shall be limited to the lesser of (a) billed charges or (b) the average charge negotiated by the ADMINISTRATOR with the institutions participating in Blue Cross and Blue Shield Association National Transplant Network, regardless of the Provider(s) you select to perform the transplant.

B. **Ambulance Service** means transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated.

C. The **Plan Administrator (ADMINISTRATOR)** is the entity selected by the CHIP Board to administer this Policy.

D. **Chemotherapy** means Chemotherapy for the treatment of a malignant disease by chemical agents that affect the causative organism unfavorably.

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

F. **Coinsurance** means the percentage of Covered Expenses for which you are responsible according to SECTION III – SCHEDULE OF BENEFITS and applies after you first satisfy your Deductible requirement.

G. **Continuation Coverage** means continuation of coverage under a Group Health Plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or state law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Section 23-86-114 of the Arkansas Insurance Code, or any other similar requirement in another state.

H. **Cosmetic Surgery** means any surgical procedure, including corrective, plastic, or reconstructive plastic surgical procedures, having the primary purpose of improving physical appearance. Cosmetic Surgery also includes any procedure required in order to correct complications caused by or arising from prior Cosmetic Surgery.

I. **Coverage Summary** means the cover sheet attached to this Policy entitled “Coverage Summary,” which summarizes your benefits under this Policy and identifies your Deductible amount and Coinsurance.

J. A **Covered Expense** means an expense for services, supplies, drugs, or articles which are Medically Necessary, and an expense which is an Allowed or Reasonable Charge not otherwise limited or excluded by the terms, conditions, and limitations of this Policy. Amounts in excess of Allowed or Reasonable Charges are not applied toward the Deductible, Coinsurance or the Maximum Lifetime Benefit.

K. **Creditable Coverage** means, with respect to a HCTC Qualified Eligible Person, coverage of the individual under any of the following:

- (1) Health Insurance Coverage (including coverage provided under a Group Health Plan);
- (2) a Group Health Plan;
- (3) Medicare;
- (4) Medical Assistance;
- (5) Chapter 55 of Title 10, United States Code;
- (6) a medical care program of the Indian Health Service or of a tribal organization;
- (7) a state health benefits risk pool;
- (8) a health plan offered under Chapter 89 of Title 5, United States Code;
- (9) a public health plan (as defined in regulations consistent with § 104 of the Health Insurance Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the U.S. Department of Health and Human Services);
- (10) a health benefit plan under § 5 (e) of the Peace Corps Act, 22 U.S.C. 2504(e).

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits (as defined in § 2791 (C) of Title XXVII of the Public Health Services Act) 42 U.S.C. § 300 gg-91, nor does it include any period of coverage under any of items (1) through (10) above that occurred before a break of sixty-three (63) days or more during all of which the individual was not covered under any of items (1) through (10) above. Any period that an individual is in a waiting period for any coverage under a Group Health Plan (or for Health Insurance Coverage) or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into

account in determining if there has been a break of sixty-three (63) days or more in any Creditable Coverage.

L. **Custodial Care** means care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills; for example, help in bathing, eating, dressing or getting in or out of bed. Custodial Care also includes care that is primarily for the purpose of separating a person from others or preventing a person from harming himself or herself.

M. **Deductible** means the Deductible amount set forth in your Coverage Summary and CHIP I.D. card, which is the amount of Covered Expenses you must pay each year from your own pocket before we will make payment for Covered Expenses.

N. **Durable Medical Equipment (DME)** means equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an Illness or Injury; and (4) is appropriate for use in the home.

O. **Excess or Stop Loss Coverage** means an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that the entire loss of a self insurance plan will exceed a specific amount.

P. **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.).

Q. **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.

R. **Health Coverage Tax Credit (“HCTC”)** means the “Health Coverage Tax Credit,” which is a federal tax credit available to HCTC Standard Eligible Persons and HCTC Qualified Eligible Persons enrolled in CHIP.

S. A **HCTC Qualified Eligible Person** is an individual who meets the criteria in the definition of a HCTC Standard Eligible Person and who has, 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.

T. A **HCTC Qualified Eligible Family Member** is a person who:

- (1) is the spouse or dependent for federal income tax purposes, of a HCTC Qualified Eligible Person covered under this Policy (except that when parents are divorced, a child cannot be a HCTC Qualified Eligible Family Member of the non-custodial parent); and
- (2) is not:
  - (a) eligible for coverage, or enrolled, in Part A or B of Medicare;
  - (b) enrolled in:
    - (i) Medical Assistance (Medicaid or ARKids First);
    - (ii) A federal employee health plan;
    - (iii) A U.S. military health plan (TRICARE/CHAMPUS);
    - (iv) a Group Health Plan or any form of Health Insurance Coverage provided through his or her, or his or her spouse’s, current or former employer, if the employer contributes more than 50% of the family’s cost of coverage;

- (v) a Group Health Plan or any form of Health Insurance Coverage provided through his or her, or his or her spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.

U. A **HCTC Standard Eligible Person** is an individual who:

- (1) is legally domiciled in Arkansas and cannot be claimed as a dependent on anyone else's federal income tax return; and
- (2) presents 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); and
- (3) is not:
  - (a) incarcerated by a federal state or local authority;
  - (b) eligible for coverage for, or enrolled in, Part A or B of Medicare;
  - (c) enrolled in:
    - (i) Medical Assistance (Medicaid or ARKids);
    - (ii) A federal employee health plan;
    - (iii) A U.S. military health plan (TRICARE/CHAMPUS);
    - (iv) a Group Health Plan or any form of Health Insurance Coverage provided through his or her, or his or her spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage;

- (v) a Group Health Plan or any form of Health Insurance Coverage provided through his or her, or his or her spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.

V. **A HCTC Standard Eligible Family Member** is a person who:

- (1) is the spouse or dependent for federal income tax purposes of a HCTC Standard Eligible Person covered under this Policy (except that when parents are divorced, a child cannot be a HCTC Standard Eligible Family Member of the non-custodial parent); and
- (2) is not:
  - (a) eligible for coverage, or enrolled, in Part A or B of Medicare;
  - (b) enrolled in:
    - (i) Medical Assistance (Medicaid or ARKids First);
    - (ii) A federal employee health plan;
    - (iii) A U.S. military health plan (TRICARE/CHAMPUS);
    - (iv) a Group Health Plan or any form of Health Insurance Coverage provided through his or her, or his or her spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage;
    - (v) a Group Health Plan or any form of Health Insurance Coverage provided through his or her, or his or her spouse's, current or former employer, if

the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.

W. **Health Insurance Coverage** means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurance company or health maintenance organization.

X. **High Dose Chemotherapy** means Chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., granulocyte colony-stimulating factor, granulocyte-macrophage colony-stimulating factor, reinfusion of stem cells, reinfusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any Insured Person who received this High Dose Chemotherapy, to prevent life threatening complications of the Chemotherapy on the Insured Person's own troginator blood cells.

Y. A **Hospital** is an institution that provides diagnostic and treatment facilities for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable laws as a general Hospital. Its services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily rest, old age or convalescent homes or acute care facilities are not considered to be Hospitals, neither are facilities operated by agencies of the federal government.

Z. **Illness** means a physical Illness or mental Illness which results in a Covered Expense. Physical Illness is a disease or bodily disorder. Mental Illness is a psychological disorder characterized by pain or distress and substantial impairment of basic functioning and is referred to in this Policy as a mentor or nervous disorder.

AA. An **In-Network Facility or In-Network Provider (In-Network Facility/Provider)** is a Hospital, Skilled Nursing Facility or Provider that has an effective contract with the ADMINISTRATOR.

BB. **Injury** means a personal bodily Injury to a person caused by accidental means.

CC. The **Insured Person** is the person in whose name this Policy is issued and who continues to satisfy the Eligibility for Enrollment requirements as outlined in SECTION VIII – ELIGIBILITY AND ENROLLMENT.

DD. **Medical Emergency** means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, could result in permanently placing a person’s health in jeopardy causing other serious medical consequences, causing serious impairment to body function, or causing serious or permanent disfunction to any body organ or part.

EE. **Medical Assistance** means the Arkansas Medical Assistance Program under Title XIX of the Social Security Act including ARKids First or under any similar program of health care benefits in a state other than Arkansas.

FF. **Medically Necessary** means that a service, supply, drug, or article is necessary and appropriate for the diagnosis or treatment of an Illness or Injury in accord with generally accepted standards of medical practice at the time the service, supply, drug, or article is provided. When specifically applied to a confinement, it further means the diagnosis or treatment of the Insured Person’s medical symptoms or condition cannot be safely provided to that person as an outpatient. A service, supply, drug, or article shall not be Medically Necessary if it:

- (1) is investigational, experimental, or for research purposes; or
- (2) is provided solely for the convenience of the Insured Person, the Insured Person’s family, physician, Hospital, or any other Provider; or
- (3) exceeds in scope, duration, or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or

- (4) could have been omitted without adversely affecting the Insured Person's condition or the quality of medical care; and
- (5) involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration.

**GG. Out of Pocket Maximum** means the maximum dollar amount of Deductible and Coinsurance that you pay out of your pocket for In-Network Covered Expenses and drugs, except for In-Network Covered Expenses for treatment of mental or nervous disorders, or chemical or drug dependency, and for Covered Expenses for drugs used to treat chemical or drug dependency. There is no Out of Pocket Maximum for Out-of-Network Covered Expenses (See subparagraph C. of SECTION IV – INFORMATION ABOUT YOUR BENEFITS.)

**HH. Pre-certification** is the process used to evaluate the medical appropriateness of proposed treatment, and the method by which the treatment will be covered under this Policy.

II. A **Provider** is any of the following, for Medically Necessary services which are within the scope of the Provider's state license or registry:

- (1) A Hospital, Skilled Nursing Facility, hospice, home health agency, physician, pharmacist, osteopath, podiatrist, or for purposes of oral surgery only, a dental surgeon, each duly licensed by the state of Arkansas;
- (2) A registered nurse or licensed practical nurse (see subparagraph L. Provider Services in SECTION V - Covered Expenses);
- (3) A physical therapist (see subparagraph L. Provider Services in the SECTION V - Covered Expenses).

- (4) Any other person or entity licensed by the state of Arkansas or the state where the services are rendered to furnish medical care, services, supplies, drugs, or articles.

JJ. **Qualified High Risk Pool** is a high risk pool that offers health insurance coverage to certain eligible individuals as defined in federal law. (See 45 C.F.R. § 148.108), and that

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

KK. **Reasonable Charge or Allowed Charge.** (See subparagraph A. under this Section II – Definitions.)

LL. A **Skilled Nursing Facility** is a facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide continuous 24-hour-a-day nursing service supervised by registered nurses.

### **III. SCHEDULE OF BENEFITS**

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A. **Summary.** The following provisions in this Section III summarize the benefits provided under this Policy for Medically Necessary services, supplies, drugs, or articles provided to an Insured Person. Other provisions of this Policy describe in detail the benefits, exclusions, limitations and other Policy provisions.

#### **B. Coinsurance Calculations**

(1) The percentage listed on the left-hand side of the back slash under In-Network/Out-Network Percentage of Allowed Charge Paid columns denote the percentage of Allowed Charges we will pay under this Policy before you reach your Out of Pocket Maximum Expense. The remaining percentage up to 100% represents your Coinsurance. See subparagraph C. of SECTION IV – INFORMATION ABOUT YOUR BENEFITS.

(2) The percentage listed on the right-hand side of the back slash under the In-Network/Out Network Percentage of Allowed Charge Paid columns in subparagraph C. denote the percentage of the Allowed Charges we will pay under this Policy after you have reached your Out of Pocket Maximum Expense. The remaining percentage up to 100% (if any) represents your Coinsurance. See subparagraph C. of SECTION IV – INFORMATION ABOUT YOUR BENEFITS.

(3) Notwithstanding subparagraphs (1) and (2), above:

(a) benefits for Skilled Nursing Facility Care are limited to 120 days each calendar year as set forth in subparagraph C. (2);

(b) your Coinsurance for residential care and outpatient treatment for chemical and drug dependency and mental and nervous disorders is 50% and each such benefit is limited to a maximum calendar year benefit of \$4,000 per Insured Person. See subparagraphs C. (3)(h) and (i) and C. (4)(e) and (f);

(c) benefits for home health care are limited up to 270 visits by a registered nurse (“RN”) or licensed practical nurse (“LPN”) per calendar year as set forth in subparagraph C. (6)(c)

(d) benefits for diabetes self-management training as prescribed by a physician are limited to one lifetime benefit as set forth in subparagraph C. (6)(d). The one lifetime benefit includes any such benefit received under a prior CHIP policy.

<b>C. Benefit Description</b>	<b><u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u></b>	<b><u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u></b>
(1) Hospital Inpatient Care		
(a) (See Pre-certification in subparagraph C. of SECTION VI. - GENERAL LIMITATIONS.)		
(b) Number of days per stay	Unlimited	Unlimited
(c) Semi-private room and additional Medically Necessary Hospital care	80%/100%	60%/80%
(d) Intensive care/coronary care unit	80%/100%	60%/80%
(2) Skilled Nursing Facility Care	80%/100%	60%/80%
(a) (See Pre-certification in subparagraph C. of SECTION VI. - GENERAL LIMITATIONS.)		
(b) Number of days	Up to 120 days each calendar year	Up to 120 days each calendar year
(3) Outpatient Care		
(a) Outpatient surgery	80%/100%	60%/80%
(b) Medical Emergency	80%/100%	80%/100%
(c) Ambulatory surgical facility	80%/100%	60%/80%
(d) Non-emergency care	80%/100%	60%/80%
(e) X-ray/radium therapy, Chemotherapy	80%/100%	60%/80%

	<u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>	<u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>
(f) Diagnostic x-ray and laboratory (For accident, Illness and pre-admission testing.)	80%/100%	60%/80%
(g) Imaging and invasive diagnostic	80%/100%	60%/80%
(h) Residential care for chemical and drug dependency (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%
(i) Residential care for mental and nervous disorders (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%
(4) Provider Care		
(a) Home and office visits (For accident or Illness.)	80%/100%	60%/80%
(b) Visits and consultations in Hospital	80%/100%	60%/80%
(c) Surgery (Surgeon, assistant surgeon, anesthesiologist and supplies.)	80%/100%	60%/80%
(d) Diagnostic x-ray and laboratory (For accident or Illness.)	80%/100%	60%/80%

	<u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>	<u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>
(e) Outpatient treatment of chemical and drug dependency (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%
(f) Outpatient treatment of mental and nervous disorders (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%
(5) Drugs Requiring A Physician Prescription	Paid At In-Network Benefit Level  80%/100% of Allowed or Reasonable Charge ( <u>except</u> for drugs to treat chemical and drug dependency, which are paid at 50% of Allowed or Reasonable Charge).	
(6) Other Services, Supplies, and Articles		
(a) Ambulance Services	80%/100%	60%/80%
(b) Supplies, appliances and Durable Medical Equipment	80%/100%	60%/80%
(c) Home health care (Up to 270 visits by RN and LPN per calendar year. See Pre-certification in subparagraph C. of SECTION VI – GENERAL LIMITATIONS)	80%/100%	60%/80%

	<u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>	<u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>
(d) Diabetes Self-Management Training (one lifetime benefit) as prescribed by a physician	80%/100%	60%/80%
(e) Equipment, supplies, and services for treatment of Type I, Type II, and Gestational Diabetes, as prescribed by a physician	80%/100%	60%/80%
(7) <b><u>Maximum Lifetime Benefit</u></b> (per Insured Person)		\$1,000,000
The maximum lifetime benefit will be reduced by benefits paid under a prior CHIP policy.		

## IV. INFORMATION ABOUT YOUR BENEFITS

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### A. Maximum Lifetime Benefit

(1) This Policy pays a percentage of Covered Expenses up to a Maximum Lifetime Benefit of \$1,000,000 for the Insured Person. However, the Maximum Lifetime Benefit of this Policy will be reduced by benefits paid under a prior CHIP policy. The explanation of how we pay and the description of Covered Expenses are given in the following sections.

(2) **IMPORTANT NOTE:** To receive full Policy benefits, you must follow the **Pre-certification** provision set forth in subparagraph C. of SECTION VI - GENERAL LIMITATIONS. In addition, it is extremely important to use an In-Network Facility or Provider in order to receive the Maximum Lifetime Benefits available under this Policy. If you require Medically Necessary care that is a Covered Expense but which is not available from any In-Network Facility or Provider, we will pay toward the cost of that service, supply, drug, or article as if it had been furnished by an In-Network Facility Provider.

(3) In all cases, we will provide benefits only when the services, supplies, drugs, or articles the Insured Person receives are Medically Necessary for treatment of an Illness or Injury and authorized by a physician.

### B. Deductibles

This Policy has a calendar year Deductible which is shown on the Coverage Summary. We will not begin to pay the Covered Expenses in any calendar year until the Deductible amount is satisfied. All Covered Expenses paid by an Insured Person count towards the calendar year Deductible.

### C. Out of Pocket Maximum Expense

(1) **In-Network — General Rule.** An Insured Person's Out of Pocket Maximum for In-Network Covered Expenses is equal to two (2) times the annual Deductible. For the purposes of calculating the Out-of-Pocket Maximum, Covered Expenses that an Insured Person pays for drugs are considered an In-Network Covered Expense. If your annual Deductible is \$1,000, your Out-of-Pocket Maximum for Covered Expenses of an In-Network Facility or Provider will equal

\$2,000--the Deductible plus \$1,000 in Coinsurance payments. If your Deductible is \$5,000, your Out-of-Pocket Maximum will be \$10,000, and if your Deductible is \$10,000 your Out of Pocket Maximum will be \$20,000. After the Out-of-Pocket Maximum is reached, CHIP pays In-Network Covered Expenses at 100%, except for Covered Expenses described in subparagraph (2), below.

(2) **In Network—Certain Expenses Excluded from Out of Pocket Maximum.** Coinsurance payments for treatment of mental or nervous disorders or chemical or drug dependency, and for drugs used to treat clinical or drug dependency, do not count towards the Out of Pocket Maximum. (See subparagraph GG. of SECTION II. - DEFINITIONS) Once the Out of Pocket Maximum is reached, you will still pay a 50% Coinsurance for these benefits, whether the benefits are provided In-Network or Out-of-Network.. If your benefits are reduced because you failed to obtain Pre-certification for an inpatient admission to a Hospital or other facility, the additional expense you pay because of this penalty also does not count towards your Out of Pocket Maximum.

(3) **Out of Network.** Coinsurance payments that an Insured Person pays for Covered Expenses of an Out-of-Network Facility/Provider do not count towards the Out of Pocket Maximum. However, once an Insured Person reaches the In Network Out of Pocket Maximum, the percentage that CHIP pays for Out-of-Network Covered Expenses increases from 60% to 80%, except for benefits paid for treatment of mental or nervous disorders, or chemical or drug dependency, which CHIP will continue to pay at 50% of Covered Expenses.

## V. COVERED EXPENSES

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The following outlines what expenses are covered subject to the other provisions of this Policy including SECTION VI. – GENERAL LIMITATIONS.

### A. Hospital Care

- (1) (See Pre-certification in subparagraph C. of SECTION VI – GENERAL LIMITATIONS.)
- (2) Care provided by a Hospital. The benefits are explained below.
- (3) Hospitalization must be authorized by a physician and must be Medically Necessary for acute care and treatment of an Illness or Injury.

B. **Hospital Benefits.** Covered Expenses consist of the following (the level of payment is listed in subparagraph C. of SECTION III - SCHEDULE OF BENEFITS):

- (1) The Allowed Charge for a semi-private room or billed charges, whichever is less.
- (2) The Allowed Charge for isolation care when we deem it necessary to protect other Insured Persons from contagion or to protect the Insured Person from contracting the Illnesses of others.
- (3) The Allowed Charge for use of an intensive care or coronary care unit. We determine our definition of an intensive care or coronary care unit by using the criteria of the Joint Commission on Accreditation of Hospitals as a guide, but we reserve the right to decide whether the unit in a particular Hospital is qualified for coverage.
- (4) The facility charges for surgery performed in a Hospital outpatient department.

- (5) Allowed Charges for other Hospital services, supplies, drugs, or articles that are Medically Necessary for treatment and are ordinarily furnished by the Hospital. These include, but are not limited to, operating and recovery rooms, traction equipment and special diets.

**C. Emergency and Out-of-State Hospital Admission.** If an Insured Person's medical condition necessitates a Medical Emergency (see Subparagraph DD. of SECTION II - DEFINITIONS) admission to a Hospital other than an In-Network Facility, coverage for a semi-private room and other Covered Expenses will be the same benefits we would have paid for similar services, supplies, drugs, or articles at an In-Network Facility. The Insured Person will be responsible for the difference between the total charge and the Allowed Charge if an Out-Of-Network Provider is used in the case of an Emergency.

**D. Inpatient Care for Chemical and Drug Dependency.** Covered Expenses for inpatient care for chemical and drug dependency are covered at 50% with a maximum annual benefit of \$4,000 per Insured Person. This maximum annual benefit will be reduced by chemical and drug dependency benefits paid under a prior CHIP policy.

**E. Inpatient Care for Mental and Nervous Disorders.** Covered Expenses for inpatient care for mental and nervous disorders are covered at 50% with a maximum annual benefit of \$4,000 per Insured Person. This maximum annual benefit will be reduced by mental and nervous disorder benefits paid under a prior CHIP policy.

**F. Emergency Room Care.** Benefits for care received in a Hospital emergency room are as follows:

- (1) **Medical Emergency:** If the Insured Person receives treatment for a Medical Emergency(see Subparagraph DD. of SECTION II - DEFINITIONS) in the emergency room of any Hospital, Covered Expenses will be paid at the percentage shown in subparagraph C. of SECTION III - SCHEDULE OF BENEFITS after the Deductible.

- (2) Non Emergency: Covered Expenses for treatment provided by an In-Network Facility or in any other Hospital emergency room for a non-emergency condition will be paid at the percentages shown in subparagraph C. of SECTION III - SCHEDULE OF BENEFITS after the Deductible.

G. **Pre-admission Testing.** Expenses for necessary pre-admission testing are covered.

H. **If Benefits Under This Policy Change.** If benefits under this Policy change while the Insured Person is in the Hospital, Covered Expenses will be based on the benefits in effect when the stay began.

I. **Skilled Nursing Facility Care**

- (1) (See Pre-certification in subparagraph C. of SECTION VI – GENERAL LIMITATIONS).
- (2) Care in a Skilled Nursing Facility is covered up to one hundred twenty (120) days per Policy year, certified sixty (60) days at a time. We may approve payment for care beyond sixty (60) days when we determine that additional Skilled Nursing Facility care is Medically Necessary for treatment of that Illness or Injury.
- (3) The Insured Person's physician must give us proof that we find acceptable, that Skilled Nursing Facility care is Medically Necessary showing that the Insured Person would require hospitalization if care in a Skilled Nursing Facility were not possible. The services must be of the type which would qualify as reimbursable services under Medicare.
- (4) Covered Expenses do not include an admission to a Skilled Nursing Facility that began before the Insured Person was enrolled under this Policy or for a stay where care is provided principally for:
  - (a) Senile deterioration;

- (b) Mental deficiency or retardation; or
  - (c) Mental Illness.
- (5) Covered Expenses for Skilled Nursing Facility care DO NOT include routine nursing care, non-medical self-help or training, personal hygiene or Custodial Care.

J. **Home Health Care.** This Policy provides benefits for the services of a certified home health agency. The Insured Person's licensed physician must give us proof that we find acceptable that home health care is Medically Necessary. Services are limited to a maximum of two hundred seventy (270) visits by an RN or LPN per calendar year. This maximum annual benefit will be reduced by benefits from RN or LPN visits paid under a prior CHIP policy.

K. **Residential Care for Chemical and Drug Dependency.** Covered Expenses for residential care are paid at 50%, with a maximum annual benefit of \$4,000. This maximum annual benefit will be reduced by chemical and drug dependency benefits paid under a prior CHIP policy.

L. **Provider Services.**

- (1) Subject to all of the policy provisions, care received from certain providers must meet specific criteria as described below.
- (a) **Physician.** This Policy covers services, supplies, drugs requiring a physician's prescription, or articles rendered by a licensed physician for professional services for diagnosis or treatment of Injuries, Illnesses or conditions, other than dental (except as provided in subparagraph (b) below), which are rendered by a licensed physician, or by other licensed professionals at his direction.
  - (b) **Dentist.** This Policy covers oral surgery for partially or completed unerupted impacted teeth and oral surgery with respect to the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(c) **RN or LPN.** This Policy covers services rendered by a licensed RN or LPN upon the written referral of a physician if those services are customarily billed to Insured Persons by nurses.

(d) **Therapists.** This Policy covers services of licensed physical therapists as ordered by a physician.

(2) Services of a Provider are explained below.

(a) **Home or Office Visits.** A “visit” means the Insured Person is actually examined by a Provider. Covered Expenses include physician consultations with written reports as well as second opinion surgery consultations.

(b) **Provider Visits in the Hospital.** Covered Expenses include Provider visits to an Insured Person during a covered Hospital or Skilled Nursing Facility stay not to exceed one visit per day. Visits relating to surgery performed during a Hospital stay are not covered, as these visits are ordinarily included in the surgeon’s fee. Covered Expenses also include physician consultations with written reports during each Hospital stay. Staff consultations required by Hospital rules are not a Covered Expense. These benefits apply only if the Insured Person is eligible for Hospital or Skilled Nursing Facility benefits.

(c) **Surgery.** Covered Expenses for surgery, (operative and cutting procedures), treatment of fractures, dislocations and burns, include those services provided by:

(i) The primary surgeon;

(ii) One assistant surgeon;

(iii) The anesthesiologist or certified anesthetist; and includes

(iv) Surgical supplies such as sutures and sterile setups when surgery is performed in the physician’s office.

(d) **High Dose Chemotherapy** is excluded except for specified treatments (See SECTION VII - GENERAL EXCLUSIONS).

(e) **Radium, Radioisotopic, and X-ray Therapy.** Covered Expenses include treatment planning and simulation; professional services for administration and supervision; and treatments including the therapist, facility, and equipment charges.

(f) **Diagnostic X-rays and Laboratory Tests.** Covered Expenses include outpatient diagnostic x-rays and laboratory tests ordered by a physician. The x-rays or tests must be related to the diagnosis or treatment of an Illness or Injury.

(g) **Imaging and Invasive Diagnostic Services.** Covered Expenses include imaging services such as MRI and CT scans, and diagnostic procedures that require entry into the body cavity, such as angiograms and endoscopy when Precertified and Medically Necessary.

(h) **Diabetes Self-Management Training.** Covered Expenses include one lifetime diabetic self-management training program when Medically Necessary as prescribed by a physician.

(i) **Outpatient Care for Chemical and Drug Dependency.** Physician services rendered in the diagnosis and/or treatment of chemical dependency will be paid at 50%, with a maximum annual benefit of \$4,000 per Insured Person. This maximum annual benefit will be reduced by chemical and drug dependency benefits paid under a prior CHIP policy.

(j) **Outpatient Care for Mental and Nervous Disorders.** Physician services rendered in the diagnosis and/or treatment of mental and nervous disorders will be paid at 50%, with a maximum annual benefit of \$4,000 per Insured Person. This maximum annual benefit will be reduced by mental and nervous disorder benefits paid under a prior CHIP policy.

## M. **Other Services and Supplies**

(1) **Ambulance Transportation.** Covered Expenses include local ground transportation by a licensed ambulance. This is for transportation to the nearest Hospital that has the facilities to provide the Medical Emergency and other Medically Necessary treatment. Certified air ambulance transportation will be covered if it is Medically Necessary, but the maximum annual benefit is limited to \$300 for a ground ambulance.

(2) **Drugs.** Covered Expenses include insulin and other drugs requiring a physician's prescription that relate directly to the treatment of an Illness or Injury. This Policy does not cover contraceptive drugs or devices, or fertility or weight loss drugs or compound drugs.

(3) **Supplies, Appliance and Durable Medical Equipment.** The following Medically Necessary supplies and appliances are Covered Expenses when required by standard treatment practices for the treatment of an Illness or Injury:

- (a) Blood or blood plasma (not covered are services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to Insured Person each Policy year);
- (b) Prosthetics (other than dental);
- (c) Casts, trusses, limb or back bones and crutches;
- (d) Rental (not to exceed the reasonable purchase price) of a wheelchair, Hospital-type bed or other Durable Medical Equipment unique to medical care or treatment;
- (e) One intraocular lens insert for each eye during or after cataract surgery. Payment for the insertion of intraocular lens is limited to \$150 to the facility only;
- (f) Oxygen; and
- (g) Equipment, supplies and services for treatment of Type I, Type II, and gestational diabetes as prescribed by a physician.

(4) **Special Dental Care.** Covered Expenses include oral surgery for partially or completely unerupted, impacted teeth and oral surgery with respect to the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

## **VI. GENERAL LIMITATIONS**

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There are limitations on the benefits available under this Policy for the treatment of certain conditions and the use of certain procedures. These limitations are explained in the following paragraphs.

### **A. Pre-existing Condition Exclusions.**

#### **(1) Who is subject to the Pre-existing Condition Exclusion?**

(a) HCTC Qualified Eligible Persons and their HCTC Qualified Eligible Family Members covered by CHIP **are not** subject to any pre-existing condition exclusions.

(b) HCTC Standard Eligible Persons and their HCTC Standard Eligible Family Members covered by CHIP **are** subject to pre-existing condition exclusions, unless any such person is eligible for and purchases the pre-existing condition waiver described in subparagraph A. (3) below.

**(2) What expenses are not covered under the pre-existing condition exclusion?** 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:

(a) 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

(b) Medical advice, care or treatment was recommended or received within the six (6) month period immediately preceding the effective date of the coverage.

(3) **Conditional Waiver.** 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 who:

(a) 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; and

(b) Have applied for CHIP coverage not later than thirty (30) days following the involuntary termination.

(4) **Cost of Waiver.** If the HCTC Standard Eligible Person or his or her HCTC Standard Eligible Family Members qualify for the waiver under subparagraph A. (3) above, the cost of purchasing the waiver is a 10% surcharge on each Insured Person's otherwise applicable annual premium, for as long as that individual's coverage under CHIP remains in effect, or sixty (60) months, whichever occurs sooner. The surcharge shall be pro-rated and charged monthly.

## B. **Subrogation.**

(1) Whenever benefits are due under this CHIP Policy because of an Illness or an Injury to an Insured Person resulting from a third party's wrongful act or negligence and the Insured Person has recovered or may recover damages from a third party or its insurance carrier or self insured entity, we shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable in the amount of damages that the Insured Person has recovered or may recover regardless of the date of the Illness or Injury or the date of any settlement, judgment, or award resulting from that Illness or Injury.

(2) During the pendency of any action or claim that is brought by or on behalf of an Insured Person against a third party or its insurance carrier or self insured entity, any benefits that would otherwise be payable shall be paid if payment by or for the third party has not yet been made and the Insured Person or, if capable, that person's legal representative agrees in writing to pay back properly the benefits paid as a result of the Illness or Injury to the extent of any future payments made by or for the third party for the Illness or Injury. This agreement is

to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

(3) Any amounts due us to repay the benefits may be deducted from other benefits payable by us after payments by or for the third party are made.

(4) Benefits due from us may be reduced or refused as an offset against any amount otherwise recoverable under this Section.

### C. **Pre-certification: How to Pre-certify.**

(1) Pre-certification is a process required for specific medical procedures and inpatient stays that documents the necessity of the care or inpatient stay and the appropriate service, supply, drug, or article or length of stay based on the proposed treatment plan. The Hospital, Provider or Insured Person contacts the ADMINISTRATOR, usually by phone, the information is evaluated, and the Medical Necessity and appropriateness of the procedure or service, supply, drug, or article is determined. Written verification or Pre-certification is provided to both the Hospital or Provider and the Insured Person.

(2) An In-Network Facility/Provider will Pre-certify Medically Necessary services, supplies, drugs, or articles for the Insured Person. If an Out Of Network Facility/Provider is used, the Insured Person is responsible for obtaining Pre-certification authorization. **Failure to obtain Pre-certification may result in an additional reduction of benefits of \$500.**

(3) Benefits will be denied for services, supplies, drugs, or articles which are not Medically Necessary (see SECTION VII - GENERAL EXCLUSIONS). Pre-certification addresses Medical Necessity only. Having a procedure pre-certified is no guarantee of benefits. All other terms, conditions, limitations, and exclusions in this Policy still apply with respect to the determination.

### D. **Chemical and Drug Dependency**

Covered Expenses for treatment of chemical and drug dependency, including drugs, are paid at 50%. The maximum annual benefits for chemical and drug dependency treatment for both inpatient and outpatient treatment, are limited

to a total of \$4,000 per Insured Person. The maximum annual benefit will be reduced by chemical and drug dependency benefits paid under a prior CHIP policy.

**E. Temporomandibular Joint Services**

Temporomandibular joint (TMJ) surgery is covered only for medical conditions when Medically Necessary. All diagnostic and surgical procedures for TMJ services must be Precertified. (See subparagraph C. above.)

**F. Transplantation**

(1) Benefits for services, supplies, drugs, or articles rendered in connection with a transplant, including pre-transplant procedures such as organ or tissue harvesting (donor costs), post-operative care (including antirejection drug treatment), and transplant related Chemotherapy for cancer must meet the definitions described below and are limited as follows:

(2) **Additional Definitions.** In addition to the definitions in SECTION II - DEFINITIONS, the following additional definitions apply to this limitation.

(a) **Covered Transplant** means medically appropriate transplant of

(i) heart;

(ii) heart/lung or lung;

(iii) kidney;

(iv) kidney and pancreas when transplanted together in the same operative session;

(v) liver;

(vi) autologous bone marrow transplantation, stem cell rescue or similar treatment procedures designed to replace or rejuvenate bone marrow or peripheral blood

cells, subject to the exclusion of High Dose Chemotherapy in SECTION VII - GENERAL EXCLUSIONS.

(b) A **Transplant** means a procedure or a series of procedures by which an organ or tissue is either:

(i) removed from the body of one person (called a **Donor**) and implanted in the body of another person (called the **Recipient**); or

(ii) removed from and replaced in the same person's body (called a **Self-Donor**).

(c) In treatment of cancer, the term "Transplant" includes any Chemotherapy and related course of treatment which the Transplant supports.

(d) **Donor Costs** means the reasonable cost of :

(i) medical services required to remove the organ or tissue from the Donor's or Self-Donor's body;

(ii) preserving it; and

(iii) transporting it to the site where the Transplant is performed.

Costs associated with locating an acceptable organ or tissue for Transplant, and other administrative or program costs, are not considered Donor Costs.

(e) **Facility Transplant Services** means all Medically Necessary services and supplies provided by a health care facility in connection with a Covered Transplant except Donor Costs and antirejection drug.

(f) **Medically Appropriate** means the Recipient or Self-Donor meets the criteria for a Transplant established by the ADMINISTRATOR.

(g) **Provider Transplant Services** means all Medically Necessary services and supplies provided by a Provider in connection with a Covered Transplant except Donor Costs and antirejection drug.

(3) **Benefits.** Benefits for Covered Transplants are payable up to the Maximum Lifetime Benefit as follows:

(a) **Facility Benefits.** We will pay for facility Transplant services according to the benefit for “Hospital Care” as set forth in subparagraph A. of SECTION V - COVERED EXPENSES of this Policy.

(b) **Provider Benefits.** We will pay for Provider Transplant services according to the benefit for “Provider Services” as set forth in subparagraph L. of SECTION V - COVERED EXPENSES of this Policy.

(c) **Donor Cost Benefits.** We will pay for Donor Costs incurred in connection with a Covered Transplant if the recipient is covered under this Policy after the Deductible has been met at 80% (In-Network Facility/Provider) or 60% (Out Of Network Facility/Provider) to the extent that benefits for Transplants remain under the Insured Person’s coverage after benefits for the Insured Person’s own expense have been paid. We will not pay toward Donor Costs if the Donor is covered under this Policy and the Recipient is not. Complications and unforeseen effects of the donation will be covered as any other Illness under the terms of this Policy only if the Donor or Self-Donor is enrolled under this CHIP plan.

(d) **Antirejection Drug Benefits.** We will pay according to the drug benefit under this Policy for antirejection drug following the Covered Transplant.

(e) **Preauthorization Requirement.**

(i) All Transplant procedures must be preauthorized for type of Transplant and must be Medically Necessary according to criteria established by the ADMINISTRATOR. Failure to preauthorize as described will result in a denial of benefits. See subparagraph C. above.

(ii) The preauthorization requirement is a part of the benefit administration of this Policy and is not a treatment recommendation. The actual course of medical treatment the Insured Person chooses remains strictly a matter between the Insured Person and his or her physician.

(4) **Limitations.** The maximum lifetime benefit under this Policy for Transplant procedures will be reduced by the amount paid for Transplant procedures for the Insured Person under a previous CHIP policy.

(5) **Exclusions.** In addition to the exclusions listed in SECTION VII - GENERAL EXCLUSIONS, we will not pay for the following:

(a) Donation related services, supplies, drug, or articles provided to an enrolled Donor if the Recipient is not enrolled under this CHIP Policy and is not eligible for transplantation benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue;

(b) Services, supplies, drug, or articles for any Transplant which is not recognized as conforming to generally accepted medical practice and which, in our judgment, is experimental or investigational;

(c) Any expense or Allowed Charge for organ or bone marrow transplants other than those performed at a Hospital with a CHIP Board approved organ Transplant program that has been designated by the CHIP Board as a preferred provider organization for that specific organ or bone marrow Transplant.

## VII. GENERAL EXCLUSIONS

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We will not pay for the following:

### A. High Dose Chemotherapy.

(1) High Dose Chemotherapy and all related procedures, including but not limited to autologous bone marrow transplantation, stem cell rescue or similar treatment or procedures designed to replace or rejuvenate bone marrow or peripheral blood cells. Other than for allogeneic bone marrow transplantation, the only instances in which services, supplies, drug, or articles associated with High Dose Chemotherapy and related procedures will be covered are in the following limited circumstances:

- (a) For a diagnosis of Non-Hodgkin's lymphoma, when classified as intermediate or high grade stage III, or stage IV;
- (b) For a diagnosis of Hodgkin's disease, when classified as stage IIIA, IIIB, IVA or IVB;
- (c) For a diagnosis of neuroblastoma, when classified as stage III or stage IV;
- (d) For a diagnosis of acute lymphocytic or non-lymphocytic leukemia following a first or any subsequent relapse;
- (e) For a diagnosis of testicular, mediastinal, retroperitoneal or ovarian germ cell tumors that are refractory to standard dose Chemotherapy with a U.S. Food and Drug Administration platinum compound. Refractory cases include (i) patients with advanced disease who fail to achieve a complete response to second-line therapy, and (ii) patients with moderate or minimal extent disease who fail to achieve a complete response to third-line therapy. Disease extent (e.g., minimal, moderate, advanced) refers to germ cell tumor stage according to the Indiana University/Einhorn Classification;

(f) For a diagnosis of metastatic breast cancer with (i) metastatic breast cancer patients who have not been previously treated with systemic Chemotherapy for metastatic disease; (ii) metastatic breast cancer that is responding to primary systemic therapy; or (iii) metastatic breast cancer that has relapsed after responding to first line treatment; and such patients have adequate marrow function with no evidence of marrow involvement of disease;

(g) For a diagnosis of multiple myeloma in patients who meet the medical criteria established by CHIP. (These criteria are available upon request from the ADMINISTRATOR's Medical Director.)

(h) For children up to eighteen (18) years of age with pineoblastoma who have shown response to standard Chemotherapy and whose disease is localized in the brain;

(i) For children or young adults up to thirty-two (32) years of age with metastatic Ewing's sarcoma.

(2) In each of the nine (9) limited cases outlined in subparagraph (1), above, the following conditions must be satisfied in order for High Dose Chemotherapy to be a Covered Expense:

(a) the patient's disease characteristics and treatment history suggest that the probability of achieving a durable, complete remission are greater with High Dose Chemotherapy compared to standard treatment or conventional dose Chemotherapy; and

(b) the patient does not have a concurrent condition which would seriously jeopardize the achievement of a durable, complete remission with High Dose Chemotherapy.

(3) Allogeneic bone marrow transplantation and all related procedures (including High Dose Chemotherapy) designed to replace bone marrow or peripheral blood cells. The only instances in which services, supplies, drug, or articles associated with allogeneic transplantation and related procedures will be

covered are in the treatment of diseases of the bone marrow listed below when the specified donor match is used:

(a) the acceptable donor matches patient at all six HLA antigens, and patient and donor cells are nonreactive in mixed leukocyte culture:

(i) aplastic anemia;

(ii) Wiskott-Aldrich syndrome;

(iii) infantile malignant osteoporosis (Albers-Schonberg syndrome or marble bone disease);

(iv) homozygous beta-thalassemia (thalassemia major);  
or

(v) Myelodysplastic Syndromes (including primary [e.g. idiopathic] and acquired [e.g. secondary to drug or toxin exposure] forms using 6 of 6 antigen matched, mixed lymphocyte culture negative, family member donor);

(b) acceptable donor matches the patient at three or more of six HLA antigens, and patient and donor cells are nonreactive in mixed leukocyte culture:

(i) severe combined immunodeficiency syndrome (e.g. adenosine deaminase deficiency and idiopathic deficiencies);

(c) for the following malignancies in which the acceptable donor is related or unrelated to the patient with matches at all six HLA loci, and patient and donor cells are nonreactive in mixed leukocyte culture:

(i) non-Hodgkin's lymphoma, intermediate or high grade stage III or stage IV;

- (ii) Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB;
  - (iii) Neuroblastoma, stage III or stage IV; or
  - (iv) chronic myelogenous leukemia in blast crisis or chronic phase.
- (d) for patients in absence of HLA identical donor, if acceptable donor is related (haploidentical) to the patient with one or more antigen mismatches, and patient and donor cells are nonreactive in mixed leukocyte culture:
- (i) acute lymphocytic or nonlymphocytic (acute myelocytic) leukemic patients who are in first or subsequent remission, but at high risk for relapse. Factors associated with high risk for relapse are:
    - (aa) age greater than 15 years;
    - (bb) leukocyte count greater than  $10 \times 10^9$  per liter;
    - (cc) extramedullary disease (especially central nervous system disease);
    - (dd) leukemic blast and chromosomal translocations; and
    - (ee) failure to achieve a complete remission within six weeks of the start of induction therapy; or
  - (ii) chronic myelogenous leukemia in chronic phase;
- (e) multiple Myeloma in patients under the age of 55 years when performed with an HLA-matched donor.

**B. Treatment Prior to Enrollment.** Services, supplies, drugs, or articles the Insured Person received before his or her effective date of coverage under this Policy.

**C. Treatments for Admissions Prior to Coverage.** Services, supplies, Prescription Drugs, or articles for an admission to a Hospital or Skilled Nursing Facility that began before the Insured Person's effective date of coverage under this Policy are excluded.

**D. Services, Supplies, drugs, or Articles** provided by a Member of Your Immediate Family.

**E. Treatment Not Medically Necessary.** Any expense or Allowed Charge for services, supplies, drugs, or articles that are not provided in accord with generally accepted standards of current medical practice and are not Medically Necessary for the treatment of an Illness or Injury are excluded.

**F. Routine Services and Supplies.** Services, supplies, drugs, or articles that, in general, do not involve treatment of an Illness or Injury are excluded. These include:

- (1) Routine physical, mental or eye examinations;
- (2) Routine tests and screening procedures, except routine Hospital pre-admission testing;
- (3) The fitting, provision or replacement of eyeglasses and hearing aids;
- (4) Telephone consultations, missed appointment, completion of claim forms or completion of reports requested by us in order to process claims;

- (5) Training programs, including, but not limited to, those to stop smoking, control weight, or provide general fitness; also excluded are those programs that teach a person how to use Durable Medical Equipment or how to care for a family member;
- (6) Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition;
- (7) Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control or education, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps or tanning lights; or
- (8) Personal items, such as telephone, televisions and guest meals, in a Hospital or Skilled Nursing Facility.

**G. Eye Exercises.**

**H. Foot Care.** Treatment for corns, calluses, removal of nails (except complete removal), and other routine foot care are excluded.

**I. Private Nursing Service** for Hospital inpatients.

**J. Treatment for Obesity or Weight Control.** Exclusions include surgery, the treatment of any complications of prior weight loss surgery, including, but not limited to, post surgical infection, follow-up visits and lab work, or any other treatment provided for weight loss programs, exercise equipment, or treatment of obesity, except when certified by a physician as morbid obesity (at least two (2) times normal body weight);

**K. Surgery to Alter Refractive Character of the Eye.** Surgical procedures which alter the refractive character of the eye, including, but not limited to, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism are excluded. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye and complications of all of these procedures are excluded.

**L. Acupuncture.** Any expense or Allowed Charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery.

**M. Massage or Massage Therapy.**

**N. Maternity Care.** Routine maternity charges for a pregnancy are excluded, except where added through an endorsement as optional coverage prior to the end of the first trimester of pregnancy and with payment of additional premiums.

**O. Orthopedic Shoes.**

**P. Cosmetic Surgery/Reconstructive Services and Supplies.** Excluded are services, supplies, and articles (including drugs) rendered for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery unless such surgery is performed to correct a functional disorder or is the result of an accidental Injury or congenital body defect to restore normal bodily functions that occurs while an Insured Person under this Policy. Cosmetic Surgery also includes any procedure required in order to correct complications caused by or arising from prior Cosmetic Surgery. The removal of breast implants is considered Cosmetic Surgery and no benefits are allowed.

**Q. Orthognathic Surgery.** Services, supplies, drugs, or articles to change the position of a bone of the upper or lower jaw (except when necessary due to an accidental Injury that occurred while an Insured Person under this Policy or when performed on an Insured Person who has been covered by us since birth) are excluded.

**R. Family Planning.** Excluded are services, supplies, drugs, or articles (including oral contraceptives) for birth control or infertility including, but not

limited to, artificial insemination, diagnosis and treatment of infertility, sterilization or sterilization reversals, or surgery to correct voluntary sterilization.

**S. In Vitro Fertilization.**

**T. Dental Examinations and Treatments** are excluded, except as specifically provided in subparagraph M. (4) entitled **Special Dental Care** of SECTION V - COVERED EXPENSES. For the purposes of this exclusion, the term “dental examinations and treatments” are services, supplies, drugs, or articles provided to prevent, diagnose or treat disease of the teeth, gingiva, the periodontal tissue and the alveolus, including services, supplies, drugs, or articles rendered to repair defects which have developed because of tooth loss and services or supplies rendered to restore the ability to chew.

**U. Physical Exercise Programs** are excluded, even though they may be prescribed for a specific condition.

**V. Sexual Disorders.** Services, supplies, drugs, or articles for the treatment of sexual dysfunction or inadequacy, or those related to sex change procedures are excluded.

**W. Custodial or Domiciliary Care** is excluded, and includes routine nursing care and rest cures; and hospitalization for environmental change.

**X. Personality or Conduct Disorders, Mental Retardation, Learning Disabilities.** Services, supplies, drugs, or articles for the treatment of a well-established pattern of behavior causing significant impairment in social or occupational functioning are excluded.

**Y. Behavior Modification.** Psychological enrichment or self-help programs for mentally healthy individuals, including assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training are excluded.

**Z. Occupational, Speech, and Audiological Therapy.**

**AA. Counseling or Treatment in the Absence of Illness** is excluded, including individual or family counseling or treatment of marital, social,

behavioral, family, occupational or religious problems; or treatment of normal transitional response to stress.

**BB. Experimental or Investigational Treatment.** Services, supplies, drugs, or articles that are, in our judgment, experimental or investigational for the diagnosis of the Insured Person being treated are excluded. Also excluded are services, supplies, drugs, or articles which support or are performed in connection with the experimental or investigational procedure. We shall have full discretion to determine whether services, supplies, drugs, or articles are experimental or investigational. Any drugs, device or medical treatment or procedure may be deemed experimental or investigational, in our discretion, if:

- (1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished;
- (2) the drug, device, treatment or procedure, or the Insured Person informed consent document utilized with the drug, device, medical treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval;
- (3) Reliable Evidence (as described in subparagraph (4) below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) **Reliable Evidence** (as defined in subparagraphs (a) – (e) below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or

its efficacy as compared with a standard means of treatment or diagnosis.

“Reliable Evidence” shall mean only the following sources:

- (a) the Insured Person’s medical records or other information from the treating physician(s) or from a consultant(s) regarding the Insured Person’s medical history, treatment or condition;
- (b) the written protocol(s) under which the drug, device, medical treatment or procedure is provided to the Insured Person;
- (c) any consent document the Insured Person has executed or will be asked to execute, in order to receive the drug, device, medical treatment or procedure;
- (d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, medical treatment or procedure at issue as applied to the Injury, Illness or condition at issue; or
- (e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

**CC. Self-Inflicted Conditions.** Services, supplies, drugs, or articles for the treatment of intentionally self-inflicted wounds, including drug overdoses, whether sane or insane, are excluded.

**DD. Service-Related Conditions.** Treatment of any condition caused by or arising out of service in the armed forces of any country or from war or insurrection is excluded.

**EE. Third Party Liability.** Services, supplies, drugs, or articles are excluded for treatment of Illness or Injury for which a third party is responsible to the extent of any recovery received from or on behalf of the third party. See

subparagraph A. (3) entitled **Third Party Liability** of SECTION XI - GENERAL PROVISIONS.

FF. **Motor Vehicle Coverage.** Services, supplies, drugs, or articles are excluded for treatment of Illness or Injury to the extent the Insured Person recovers or is entitled to recover from motor vehicle insurance including, but not limited to, primary medical payments coverage, uninsured motorist or underinsured motorist coverage. See subparagraph A. (2) entitled **Motor Vehicles Coverage** of SECTION XI - GENERAL PROVISIONS.

GG. **Work-Related Conditions.** Services, supplies, drugs, or articles are excluded for treatment of Illness or Injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service, supply, drug, or article is paid under Workers' Compensation. The only exception would be if the Insured Person is exempt from state or federal Workers' Compensation law. See subparagraph A. (4) entitled **Workers' Compensation** of SECTION XI - GENERAL PROVISIONS.

HH. **Services Otherwise Available** are excluded. This category includes:

- (1) Services, supplies, drugs, or articles for which payment could be obtained in whole or in part if the Insured Person had applied for payment under any city, county, state or federal law;
- (2) Services, supplies, drugs, or articles the Insured Person could have received in a Hospital or program operated by a government agency or authority, unless the Insured Person is a veteran of the armed forces, in which case Covered Expenses for services, supplies, drugs, and/or articles which are furnished by the Veteran's Administration of the United States and which are not service-related are eligible for payment according to the terms of this Policy;
- (3) Services, supplies, drugs, or articles for which no charge is made, or for which no charge is normally made in the absence of insurance;

(4) Medicare and Medicaid or other Medical Assistance plans.

II. **Charges Over Benefits Authorized Under This Policy.** Excluded is that part of any Allowed Charge for services or supplies rendered or articles or drugs prescribed by a physician, dentist or other health professional which exceeds the prevailing charge in the locality or for any charge not Medically Necessary.

JJ. **Benefits Not Stated.** Services, supplies, drugs, or articles not specifically described as benefits under this Policy are excluded.

## VIII. ELIGIBILITY AND ENROLLMENT

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### A. When Coverage Begins.

(1) **General Rule.** Coverage begins on the first of the month after we have accepted and approved an application for enrollment. The HCTC Standard Eligible Person or HCTC Qualified Eligible Person (“Applicant”) completes one application for him or herself and his or her spouse and dependents.

(2) **Newborn Children.** A newborn child of an Insured Person may be covered from the date of birth if the Insured Person applies for coverage within thirty-one (31) days after the child’s birth. See subparagraph C. (3) below.

B. **Policy Issued to Each Insured Person.** By signing the application form, the Applicant represents that all information provided in the application and supporting materials is accurate. However, CHIP issues a separate policy for each family member who qualifies for coverage based on the application and supporting documents. **If the Applicant provides inaccurate information in the application about a spouse or dependent, both the Policy of the Applicant and the Policy of the spouse or dependent may be subject to termination by us.**

### C. **Eligibility for Coverage.**

#### (1) **HCTC STANDARD ELIGIBILITY.**

(a) **HCTC STANDARD ELIGIBLE PERSONS.** To be eligible for coverage as a HCTC Standard Eligible Person, an individual must:

(i) meet the criteria in the definition of HCTC Standard Eligible Person (see subparagraph U. of SECTION II - DEFINITIONS of this Policy);

(ii) provide evidence to the ADMINISTRATOR:

(aa) 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 is not a rejection or refusal to issue substantially similar individual Health Insurance Coverage.*)

(bb) 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

(cc) 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.

(iii) except under circumstances described in subparagraphs (aa) and (bb), below, not be enrolled in or eligible for other Health Insurance Coverage substantially similar to or more comprehensive than this CHIP Policy, including coverage under a Group Health Plan, Part A or B of Medicare or Medical Assistance;

(aa) a person may maintain other coverage for the period of time such person is satisfying any pre-existing condition waiting period under this Policy; and

(bb) 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 any other coverage intended to replace this Policy.

(iv) not have previously terminated CHIP coverage in the twelve (12) months prior to the date the HCTC Standard Eligible Person applies for CHIP coverage;

(v) not have previously received CHIP benefits equaling \$1,000,000 or more;

(vi) not be a resident of a public institution; and

(vii) not 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:

(aa) as advance payment on the Health Care Tax Credit allowed by Section 35 of the Internal Revenue Code; or

(bb) on behalf of an otherwise qualifying full time employee, or dependent of such employee, of a government agency or health care Provider

**(b) HCTC STANDARD ELIGIBLE FAMILY MEMBERS.** A spouse or dependent of a **HCTC Standard Eligible Person** may be enrolled for coverage if:

(i) he or she meets the criteria in the definition of HCTC Standard Eligible Family Member (see subparagraph V. of SECTION II - DEFINITIONS of this Policy); and

(ii) the HCTC Standard Eligible Person applies for coverage for the HCTC Standard Eligible Family Member at the same time he or she applies for coverage, or within 31 days after the HCTC Standard Eligible

Family Member first qualifies for coverage under subparagraphs (i) above. (There are special rules that apply to coverage for newborn children. See subparagraph (3) below.)

**(2) HCTC QUALIFIED ELIGIBILITY.**

**(a) HCTC QUALIFIED ELIGIBLE PERSONS.** To be eligible for coverage as a HCTC Qualified Eligible Person, the individual must:

- (i) meet the criteria in the definition of a HCTC Qualified Eligible Person (see subparagraph S. of SECTION II - DEFINITIONS of this Policy); and
- (ii) submit to the ADMINISTRATOR an application and all required supporting documentation, including acceptable written certificates of previous Credible Coverage, within sixty-three (63) days after the termination of prior Credible Coverage.

**(b) HCTC QUALIFIED ELIGIBLE FAMILY MEMBERS.** A spouse or dependent of a **HCTC Qualified Eligible Person** may be enrolled for coverage if:

- (i) he or she meets the criteria in the definition of HCTC Qualified Eligible Family Member (see subparagraph T. of SECTION II – DEFINITIONS of this Policy); and
- (ii) the HCTC Qualified Eligible Person applies for coverage for the HCTC Qualified Eligible Family Member at the time he or she applies for coverage, or within 31 days after the HCTC Qualified Eligible Family Member first qualifies for coverage under subparagraph (i), above. (There are special rules that apply to coverage for newborn children. See subparagraph (3), below).

**(3) SPECIAL RULES FOR NEWBORN CHILDREN.** The following rules apply to newborn natural children of Insured Persons:

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

(i) the HCTC Qualified Eligible Person or HCTC Standard 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;

(ii) the premium for the Newborn's CHIP Policy is paid when the Policy is issued; and

(iii) the newborn child meets the criteria for a HCTC Qualified Eligible Family Member (see subparagraph T. of SECTION II - DEFINITIONS of this Policy or a HCTC Standard Eligible Family Member (see subparagraph V. of Section II – Definitions of this Policy).

**(b) Newborn child of other Insured Persons.** The newborn child of other Insured Persons not listed in subparagraph (a) above will be issued a CHIP Policy providing coverage from the date of birth, if:

(i) 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;

(ii) the premium for the newborn's CHIP Policy is paid when the Policy is issued;

(iii) the newborn child is not eligible for coverage under any Health Insurance Coverage, Group Health Plan or any other health benefits coverage whether insured, self insured or a governmental program; and

(iv) the newborn child is a resident of the State of Arkansas.

## **IX. PREMIUM PAYMENTS.**

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A. **Definition.** For the purposes of this Section IX, “Covered Family Member” refers to both:

(1) an Insured Person issued a Policy because he or she is eligible for the Health Coverage Tax Credit, either as a HCTC Standard Eligible Person or a HCTC Qualified Eligible Person; and

(2) a spouse or dependent of such Insured Person issued a Policy because he or she is a HCTC Standard Eligible Family Member or a HCTC Qualified Eligible Family Member.

B. **Separate Deductible and Age-Based Premium Rates for Each Covered Family Member.** CHIP charges a separate rate for each Covered Family Member. The rate varies by the selected Deductible and the age of the Covered Family Member. There is no group or family rate.

C. **Responsibility for Payment.** CHIP will bill each Covered Family Member for the premium owed under the Policy issued to each such Covered Family Member. If the entire amount due under such Policy is not paid in full in accordance with this Section IX, the Policy is subject to cancellation under Section X of the Policy.

D. **Method of Payment.** A HCTC Standard Eligible Person or HCTC Qualified Eligible Person is responsible for applying for coverage for both him or herself and his or her spouse and dependents. Upon approval of coverage, CHIP sends each Covered Family Member an approval letter containing a premium billing that the Covered Family Member must pay for the first month of coverage. The first month’s premiums must be paid in full directly to CHIP, unless you make the first month’s payment through the Health Coverage Tax Credit (HCTC) Processing Center, as described below. Subsequent month’s payments may be made through the HCTC Processing Center, by monthly bank draft or by quarterly payment by check. The three payment options are described below.

(1) **HCTC Processing Center.**

(a) **Submitting documentation and payments to Processing Center.** Pursuant to federal law, the Internal Revenue Service has arranged to pay the Health Coverage Tax Credit in advance by paying 65% of the premium payments of each Covered Family Member. Under this option, the HCTC Standard Eligible Person or the HCTC Qualified Eligible Person must follow the procedures below to ensure continued CHIP coverage for each Covered Family Member:

(i) Enroll with the HCTC Processing Center and submit the CHIP approval letter showing the first month's premium for each Covered Family Member to the HCTC Processing Center. The HCTC Processing Center will collect from the HCTC Standard Eligible Person or HCTC Qualified Eligible Person 35% of the premium for each Covered Family Member, add the remaining 65% of each Covered Family Member's premium and pay the entire premium for each Covered Family Member to CHIP.

(ii) Pay the 35% share of each Covered Family Member's premium to the HCTC Processing Center in a timely manner.

(iii) Notify the HCTC Processing Center if a Covered Family Member's premium increases.

(b) **CHIP must receive payment in full.** If CHIP does not receive the correct amount of premium from the HCTC Processing Center for each Covered Family Member, then coverage for any such Covered Family Member whose premium is not paid is subject to termination in accordance with Section X of this Policy.

- (2) **Monthly Bank Drafts.** CHIP will accept monthly payments of a Covered Family Member's premium if payment is made by automatic transfer from a checking or savings account. If a HCTC Standard Eligible Person or HCTC Qualified Eligible Person pays CHIP directly through this method, he or she must pay the premium for each Covered Family Member in full and claim the Health Coverage Tax Credit on his or her taxes rather than receiving it in advance through the HCTC Processing Center.
- (3) **Quarterly payment.** CHIP also will invoice a Covered Family Member on a quarterly basis. If CHIP is paid directly through this method, the HCTC Standard Eligible Person or the HCTC Qualified Eligible Person must pay the premium for each Covered Family Member in full and claim the Health Coverage Tax Credit on his or her taxes rather than receiving it in advance through the HCTC Processing Center.

E. **When Payments Are Due.** Premium payments are due in advance for all payment methods. CHIP allows a 30-day grace period after the premium due date. All claims submitted under this Policy may be placed in suspense and not be adjudicated or acted upon during a grace period until the premium due is paid. If the premium payment for a Covered Family Member is not made within the grace period, CHIP may terminate the Covered Family Member's Policy without notice in accordance with Section X of this Policy. A Covered Family Member's coverage will end on the last day of the calendar month for which premiums were paid. The monthly coverage period is the first to the last day of the month.

F. **Renewal.** This Policy is renewed each time a premium payment is made. If the payments are made monthly, this Policy is renewed for one (1) month. If payments are made every three (3) months, the Policy is renewed for three (3) months.

**G. Changes in Premium Rate.**

(1) As stated in subparagraph B above, the premiums under this Policy are age rated. This means the premium will always increase at each five (5) year interval on the next premium due date when the Insured Person reaches age 20, 25, 30 or 35, etc.

(2) We will give the Covered Family Member at least forty-five days' written notice before his or her premium is increased for age or for any other reason.

(3) If a Covered Family Member's premium is paid through the HCTC Processing Center, the HCTC Standard Eligible Person or the HCTC Qualified Eligible Person is responsible for notifying the Processing Center of any premium increases so that the Processing Center pays CHIP the appropriate premium.

## **X. WHEN THIS COVERAGE ENDS**

A. **Your thirty-day right to terminate.** You may cancel this Policy within thirty (30) days after receiving it by returning the Policy to us. If you decide to cancel, any unearned premiums paid will be refunded.

B. **Immediate Termination without Notice.** This Policy will terminate automatically without notice on the date of your death, or if Arkansas law requires immediate cancellation.

C. **Termination upon 30 days' notice.** CHIP may, at its option, terminate this Policy thirty (30) days after CHIP makes any written inquiry to you concerning eligibility or place of residence to which you do not reply.

D. **Termination at the end of current monthly coverage period for which premium has been paid.** This Policy will terminate automatically without notice at the end of the current monthly coverage period for which you have paid premium, if during the monthly coverage period:

- (1) the HCTC Standard Eligible Person or the HCTC Qualified Eligible Person who applied for this Policy is no longer legally domiciled in Arkansas;
- (2) you request coverage to end;
- (3) you are a HCTC Standard Eligible Person and:
  - (a) you no longer are eligible for the Health Coverage Tax Credit under federal law;
  - (b) you have, obtain *or are eligible for* Health Insurance Coverage substantially similar to or more comprehensive than this Policy, including coverage under a Group Health Plan, Part A or B of Medicare or Medical Assistance, except that:

- (i) you may maintain other coverage for the period of time you are satisfying any pre-existing condition waiting period under this Policy; and
  - (ii) you may maintain this Policy for the period of time you are satisfying a pre-existing condition waiting period under another Health Insurance Coverage or a Group Health Plan or any other coverage intended to replace this Policy;
- (c) CHIP discovers you had previously terminated CHIP coverage within the past twelve (12) months;
- (d) the required premium under this Policy has not been paid in full, in which event the liability under this Policy shall be limited to benefits incurred under this Policy for the monthly coverage period for which premiums have been paid and you remained eligible for coverage under this Policy;
- (e) you have received a total of \$1,000,000 in CHIP benefits during your lifetime;
- (f) you become a resident of a public institution;
- (g) your premium is paid for or reimbursed under any government sponsored program or by any government agency or health care Provider, except premiums paid as advance payment on the Health Coverage Tax Credit allowed by section 35 of the Internal Revenue Code, or on behalf of an otherwise qualifying full time employee, or dependent of such employee, of a government agency or health care Provider; or
- (h) you become incarcerated by a federal, state or local authority;
- (4) You are a HCTC Standard Eligible Family Member and:

- (a) the HCTC Standard Eligible Person through which you are eligible for coverage loses eligibility for coverage;
- (b) you are no longer the spouse or dependent for federal income tax purposes of the HCTC Standard Eligible Person (because of divorce, aging out of dependent status, etc.);
- (c) you become eligible for coverage for, or are enrolled in, Part A or B of Medicare; or
- (d) you become enrolled in:
  - (i) Medical Assistance (Medicaid or ARKids);
  - (ii) A federal employee health plan;
  - (iii) A U.S. military health plan (TRICARE/CHAMPUS);
  - (iv) a Group Health Plan or any form of Health Insurance Coverage provided through your, or your spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage;
  - (v) a Group Health Plan or any form of Health Insurance Coverage provided through your, or your spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.
- (5) You are a HCTC Qualified Eligible Person and:
  - (a) You no longer are eligible for the Health Coverage Tax Credit under federal law;
  - (b) you become eligible for coverage for, or are enrolled in, Part A or B of Medicare;

- (c) you become enrolled in:
  - (i) Medical Assistance (Medicaid or ARKids);
  - (ii) A federal employee health plan;
  - (iii) A U.S. military health plan (TRICARE/CHAMPUS);
  - (iv) a Group Health Plan or any form of Health Insurance Coverage provided through your, or your spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage;
  - (v) a Group Health Plan or any form of Health Insurance Coverage provided through your, or your spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.
- (d) you become incarcerated by a federal, state or local authority.
- (6) if you are a HCTC Qualified Eligible Family and:
  - (a) the HCTC Qualified Eligible Person through which you are eligible for coverage loses eligibility for coverage;
  - (b) you are no longer the spouse or dependent for federal income tax purposes of the HCTC Qualified Eligible Person (because of divorce, aging out of dependent status, etc.);
  - (c) you become eligible for coverage for, or are enrolled in, Part A or B of Medicare; or
  - (d) you become enrolled in:

- (i) Medical Assistance (Medicaid or ARKids);
- (ii) A federal employee health plan;
- (iii) A U.S. military health plan (TRICARE/CHAMPUS);
- (iv) a Group Health Plan or any form of Health Insurance Coverage provided through your, or your spouse's, current or former employer, if the employer contributes more than 50% of the family's cost of coverage;
- (v) a Group Health Plan or any form of Health Insurance Coverage provided through your, or your spouse's, current or former employer, if the employer provides the coverage in lieu of cash or other benefits under a cafeteria plan.

**E. Refusal to Renew all Policies of the same form.** We may refuse to renew your Policy if we refuse to renew all other policies of the same form, and such nonrenewal is permitted or required under applicable law or regulation.

## **XI. GENERAL PROVISIONS.**

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A. **Benefits Available From Other Sources.** Situations may arise in which your health care expenses are the responsibility of a source other than CHIP. Here are descriptions of the situations that may arise and how this Policy will be administered:

(1) **Medicare/Medical Assistance** We will not duplicate benefits payable through or by Medicare or Medical Assistance for an Insured Person who is enrolled in Medicare or Medical Assistance.

(2) **Motor Vehicle Coverage.** In addition to liability insurance, motor vehicle insurance policies may provide primary medical payment insurance, uninsured motorist insurance, and underinsurance coverage. Benefits for Covered Expenses are excluded under this Policy to the extent that you are entitled to recovery from motor vehicle insurance, but we will pay benefits toward Covered Expenses over the amount covered by motor vehicle insurance. Here are some rules which apply with regard to motor vehicle insurance coverage:

(a) If a claim for health care expense arising out of a motor vehicle accident is filed with us and motor vehicle insurance has not yet paid, we may advance benefits for Covered Expenses as long as you agree in writing:

(i) to give us information about any motor vehicle insurance coverage which may be available to you; and

(ii) to hold the proceeds of any recovery from motor vehicle insurance in trust for us and reimburse us as provided below.

(b) If we have paid benefits before motor vehicle insurance has paid, we are entitled to reimbursement of the benefits we paid out of any subsequent motor vehicle insurance recovery or

payment made to or on your behalf whether such recovery or payment is from primary medical payments coverage, uninsured motorist coverage or underinsured motorist coverage.

(c) If you incur health care expenses for treatment of an Illness or Injury arising out of a motor vehicle accident after receiving a recovery from uninsured or underinsured motor vehicle coverage, we will exclude benefits for otherwise Covered Expenses until the total amount of health care expenses incurred after recovery equals or exceeds the net recovery amount (as defined in the “Third Party Liability” provision).

(d) If you were involved in a motor vehicle accident you may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the “Third Party Liability” provision apply.

(3) **Third Party Liability.** This provision applies when you incur health care expenses in connection with an Illness or Injury for which one or more third parties may be responsible. In that situation, benefits for Covered Expenses are excluded under this Policy to the extent you receive a recovery from or on behalf of the responsible third party. Here are some rules which apply in these third party liability situations:

(a) If a claim for health care expenses is filed with us and you have not yet received recovery from the responsible person, we may advance benefits for Covered Expenses if you agree in writing to hold any recovery in trust for us up to the amount of benefits we pay. We may require that you sign an agreement guaranteeing our right to reimbursement before we advance any benefits.

(b) If we have already paid benefits, we will be entitled to reimbursement of the benefits we have paid from the proceeds

of any recovery you receive from or on behalf of the third party.

(c) We are entitled to full reimbursement of the benefits we have paid from the proceeds of any recovery you received from or on behalf of the third party. This is true regardless of whether:

(i) the recovery is the result of a court judgment, arbitration award, compromise settlement or any other arrangement;

(ii) the third party or the third party's insurer admits liability; or

(iii) the health care expenses are itemized or expressly excluded in the third-party recovery.

(d) We will allow a deduction of a proportionate share of the reasonable expenses of obtaining a recovery such as attorney fees and court costs from the amount to be reimbursed to us.

(e) If you incur health care expenses for treatment of the Illness or Injury after receiving a recovery, we will exclude benefits for otherwise Covered Expenses until the total amount of health care expenses incurred after the recovery equals or exceeds the net recovery amount.

(f) The "net recovery amount" referred to in subparagraph 3(e) above shall be calculated as follows:

- (i) Gross Recovery
  - (aa) Amount of Recovery <sup>1</sup>
  - (bb) Amount of Other Source of Recovery <sup>2</sup>
  - (cc) Gross Recovery Amount <sup>3</sup>

- (ii) Deductions from Gross Recovery
  - (aa) Unpaid Claims <sup>4</sup>
  - (bb) Reimbursement from Recovery Funds <sup>5</sup>
  - (cc) Cost of Recovery Action <sup>6</sup>
  - (dd) Total Deductions from Gross Recovery <sup>7</sup>
  
- (iii) Net Recovery <sup>8</sup>
  
- (iv) Footnotes contained in subparagraphs 3(f)(i), (ii), and (iii) are as follows:
  - 1 - The amount received from the responsible party.
  - 2 - Any other amount received on behalf of the responsible party.
  - 3 - The sum of items 1 and 2.
  - 4 - Pre-recovery health expenses incurred which are the responsibility of a third party less pre-recovery benefits paid by us.
  - 5 - The sum of payments to us, other insurers or lienholder for pre-recovery health expenses.
  - 6 - The sum of reasonable attorney fees, court costs, and other costs of obtaining recovery.
  - 7 - The sum of items 4, 5 and 6.
  - 8 - Gross Recovery less Deductions from Gross Recovery.

(4) **Workers' Compensation.** This provision applies if you have made or are entitled to make a claim for workers' compensation benefits. Benefits for treatment of Illness or Injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Policy. The only exception is when you are exempt from state or federal workers' compensation law. Here are some rules which apply in situations where a workers' compensation claim has been filed:

(a) You must notify us in writing within ten (10) days of filing a workers' compensation claim.

(b) If the entity providing workers' compensation coverage has denied your claim and you have filed an appeal, we may advance benefits for Covered Expenses if you agree in writing:

(i) to hold any recovery you obtain from the entity providing workers' compensation coverage in trust for us up to the amount of benefits we pay;

(ii) to keep us fully informed of any settlement discussions entered into in connection with the workers' compensation claim and to give written notice prior to entering into any disputed claim settlement agreement; and

(iii) if we and the entity providing workers' compensation coverage cannot agree on liability or reimbursement owed to us, you agree to cooperate and help us in any proceeding to determine liability or reimbursement.

(c) If we have already paid benefits, we will be entitled to reimbursement of the benefits we have paid from the proceeds of any recovery you receive from or on behalf of the entity providing workers' compensation coverage.

(d) We are entitled to full reimbursement of the benefits we have paid from the proceeds of any recovery you received from or on behalf of the entity providing workers' compensation coverage. This is true regardless of whether:

(i) the recovery is the result of an arbitration award, compromise settlement or any other arrangement;

(ii) the entity providing workers' compensation coverages admits liability; or

(iii) the health care expenses are itemized or expressly excluded in the recovery.

(e) We will allow a deduction of a proportionate share of the reasonable expenses of obtaining a recovery such as attorney fees and court costs from the amount to be reimbursed to us.

(f) If you incur health care expenses for treatment of the Illness or Injury after receiving a recovery, we will exclude benefits for otherwise Covered Expenses until the total amount of health care expenses incurred after the recovery equals or exceeds the net recovery amount.

- (5) **Duplication of Benefits.** Benefits payable through the Arkansas Comprehensive Health Insurance Pool (CHIP) are reduced by amounts payable through any other Health Insurance Coverage, self-insurance arrangement, a Group Health Plan, or other coverage providing Hospital and Provider benefits. CHIP does not duplicate benefits paid through another plan or any other source (as defined in the “Third Party Liability” provision).

**B. Determining Continued Medical Necessity.**

(1) If you are receiving benefits and a question arises about the Medical Necessity of continued care, the attending physician will be asked to submit evidence to support the judgment that continued care is Medically Necessary. We may request proof of Medical Necessity once every thirty (30) days. In addition, such evidence may also be considered by a medical review board at either party’s request.

(2) We will not continue benefits for the care unless the physician supplies medical information that proves that continued care is Medically Necessary and the medical review board agrees.

**C. Alternative Services.**

(1) In any case which meets the following three conditions, we shall have the right to pay benefits for alternative services not otherwise covered by this Policy:

- (a) Alternative services that are Medically Necessary;
- (b) Major continuing claims expense is anticipated; and
- (c) You or your duly authorized representative, and the physician, approve the use of alternative services.

(2) Payment of benefits for alternative services shall be at the sole discretion of CHIP, based on its evaluation of the individual case. The fact that we have paid benefits for alternative services for you shall not obligate us to pay benefits for continued or additional alternative services for you. All amounts we pay for alternative services under this provision shall be considered Covered Expenses.

**D. Coordinated Care Services.** We may offer special services (Coordinated Care Services), including care assessment and case management services to you in cases of chronic or catastrophic medical conditions. The specific services to be provided will be determined on a case-by-case basis. The program is voluntary, and services offered through the program will not go into effect until you approve.

**E. You Must Submit Medical Information.** We may require you to submit information concerning benefits to which you are entitled when necessary to process claims. We may also require you to authorize any health care Provider to give us information about a condition for which you claim benefits.

**F. Benefits Are Not Transferable.** Only you, the Insured Person, are entitled to benefits under this Policy. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on us.

**G. When Benefits Are Available.**

(1) This Policy pays benefits for Covered Expenses incurred only when coverage is in effect. Coverage is in effect when you:

- (a) Are eligible to be covered according to the eligibility provisions of this Policy;
- (b) Have applied for coverage and have been accepted by us; and
- (c) Have paid the premium as required.

(2) The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to you.

## **H. Submission and Payment of Claims.**

### **(1) Circumstances When You Must Submit Claims.**

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

(b) In most other cases, you do not have to file a claim for benefits since most Hospitals and Providers will bill us directly. However, you will have to send us the itemized bill when:

(i) a Provider bills you directly;

(ii) a Hospital bills you directly;

(iii) a Provider of other services, supplies, drugs, or articles bills you directly; or

(iv) you receive care from a Provider or facility located outside of Arkansas.

(c) After paying for a drug requiring a physician's prescription or in other cases described above, send us the itemized bills (be sure to keep copies of your record since we cannot return the ones you send us). Be sure the bill includes

the following information:

- (i) Your name (the patient) and identification numbers;
  - (ii) The name of the dispensing pharmacy;
  - (iii) A description of the symptoms that were observed or a diagnosis; and
  - (iv) A description of the services, supplies, drugs, or articles and the dates on which they were given.
- (d) If the treatment is for an accidental Injury, include a statement explaining the date, time, place, and the circumstances of the accident when you send us the bill.
- (e) Soon after you make a claim, we will report to you the action we have taken. This will be done on a form called an Explanation of Benefits. We may pay claims, deny them, or accumulate them toward satisfying the Deductible. If we deny all or part of the claim, the reason for our action will be stated in the Explanation of Benefits.

(2) **Deadline for Submitting Claims.** You must submit written proof of any services, supplies, drugs, or articles or treatment and the charges to the ADMINISTRATOR **not later than six (6) months from the date such services, supplies, drugs, or articles or treatment were received.** The failure to file a claim for a Covered Expense within this deadline will cause such Covered Expense to be excluded from coverage under this Policy.

(3) **Processing your claim.**

- (a) The ADMINISTRATOR, upon receipt of notice of a claim, will furnish to you such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the ADMINISTRATOR receives such notice, you shall be deemed to have complied with the requirements as to proof of loss upon submitting, within the

time fixed for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

(b) Subject to all applicable statutory provisions and rules and regulations of the Arkansas Insurance Department, all benefits payable under this Policy will be payable immediately upon receipt of written proof of loss.

(4) **Claims Appeal.**

(a) If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the CHIP Appeals Coordinator, in care BlueAdvantage Administrators, 320 W. Capitol Avenue, Suite 500, Little Rock, Arkansas 72201 or P.O. Box 1460, Little Rock, Arkansas 72207. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

(b) In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. You or your duly authorized representative may submit, with your request for review, any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.

(c) If you are still not satisfied at this point, you have the right to file an appeal with the Grievance Committee of the Board of Directors of the Arkansas Comprehensive Health Insurance Pool within 30 days of the final decision of the CHIP Appeals Coordinator. The Grievance Committee shall act on

the grievance within 60 days of the receipt of the grievance unless a later date is agreed to by you and the Grievance Committee. You may make a final appeal to the full CHIP Board within 30 days of the determination of the Grievance Committee. You have the right to request a hearing before the Board upon request. The Board will act on your appeal within 30 days of receipt unless a later date is agreed to in writing by you and the Board.

(d) Appeals to the Grievance Committee and Board as set forth in subparagraph (c) above must be addressed as follows:

CHIP  
c/o Nick Thompson  
P.O. Box 419  
Little Rock, AR 72203

(5) **Recovery of Benefits Paid by Mistake.** If we mistakenly make a payment on your behalf to which you are not entitled, or if we pay a person who is not eligible for payment at all, we have the right to recover the payment from the person we paid or anyone else who benefited from it, including any Provider of health care services, supplies, drugs, or articles. Our right of recovery includes the right to deduct the amount paid by mistake from your future benefits if the mistaken payment was made on your behalf.

**I. We Are Not Responsible for the Quality of Medical Care.**

In all cases, you have the exclusive right to choose your facility or Provider. We are not responsible for the quality of medical care you receive, since all those who provide care do so as independent contractors. We cannot be held liable for any claim or damages connected with injuries you may suffer while receiving medical services, supplies, drugs, or articles.

**J. Parties Do Not Lose Their Rights.**

The fact that either party to this Policy ignores any violation of this Policy will not prevent that party from insisting on strict observance of all provisions of this Policy in the future.

## **XII. CHANGING THIS POLICY**

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This Policy cannot be changed except by a written endorsement issued by us. We may change this Policy by giving you thirty (30) days advance written notice.

## **XIII. NOTICES UNDER THIS POLICY**

Any notice we are required to give under this Policy will be mailed to you at the address appearing in our records. Any notice you have to give must be mailed to us at:

**Arkansas Comprehensive Health Insurance Pool**  
BlueAdvantage Administrators  
320 W. Capitol Avenue, Suite 500  
Little Rock, AR 72201

OR

P.O. Box 1460  
Little Rock, Arkansas 72203  
1-800-285-6477

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Michael D. Wilkinson, Chairman  
Arkansas Comprehensive Health Insurance Pool