

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

Policy Form

Administered by

BlueAdvantage

Administrators of Arkansas

320 W. Capitol Avenue, Suite 500•

Little Rock, Arkansas 72201

OR

P. O. Box 1460

Little Rock, AR 72203-1460

1-800-285-6477

Arkansas Comprehensive Health Insurance Pool (CHIP)

You may cancel this Policy within thirty (30) days after you receive it by returning it to us. If you decide to cancel, any premiums paid will be refunded. This Policy will terminate automatically without notice at the end of the current monthly coverage period for which you have paid premium, as outlined in the GENERAL PROVISIONS section of this Policy, if during the monthly coverage period:

You are a Resident Eligible Person and you;

- (A) have or obtain health insurance coverage substantially similar to or more comprehensive than this Policy or you would be eligible to have health insurance coverage, including coverage under a Group Health Plan, Part A or B of Medicare or Medical Assistance, if you elected to obtain it, 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 Policy intended to replace this Policy;
- (B) had previously terminated CHIP coverage unless twelve (12) months have elapsed since termination of CHIP coverage;
- (C) have failed to pay the required premium under this Policy 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;

- (D) have received a total of \$1,000,000 in CHIP benefits during your lifetime;
- (E) are a resident of a public institution; or
- (F) had your premium paid for or reimbursed under any government sponsored program or by any government agency, foundation or health care Provider, except as a otherwise qualifying full-time employee or dependent of such an employee of a government agency, foundation or health care Provider.

You are a Federally Eligible Individual and you;

- (a) are eligible for coverage under:
 - (i) a Group Health Plan;
 - (ii) Part A or B of Medicare;
 - (iii) Medical Assistance from the Arkansas Medicaid program;
- (b) have other health insurance coverage;
- (c) have failed to pay the required premium under this Policy in which even 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; or
- (d) have received a total of \$1,000,000 in CHIP benefits during your lifetime.

This Policy will terminate automatically without notice as outlined in the GENERAL PROVISIONS section of this Policy:

- * on the date you are no longer a resident of the state of Arkansas;
- * on the date you request coverage to end;
- * on the date of your death;
- * on the date Arkansas law requires cancellation of this Policy; or
- * at CHIP's option, thirty (30) days after CHIP makes any written inquiry concerning your eligibility or place of residence to which you do not reply.

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 Pre-existing Condition Exclusion Waiver in order to receive coverage for pre-existing conditions that otherwise may be excluded from coverage under this Policy (see GENERAL LIMITATIONS).

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.

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This Policy consists of this document, your application, 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.

DEFINITIONS

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

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.

The **Plan Administrator (ADMINISTRATOR)** is BlueAdvantage Administrators of Arkansas, the entity selected by the CHIP Board to administer this Policy.

Chemotherapy means Chemotherapy for the treatment of a malignant disease by chemical agents that affect the causative organism unfavorably. High Dose Chemotherapy is 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.

Church Plan has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

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.

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.

A **Covered Expense** means an expense for services, supplies, drugs, or articles which are Medically Necessary and an expense which is a Reasonable or Allowed Charge not otherwise limited or excluded by the terms, conditions, and limitations of this Policy. Amounts in Excess of Reasonable or Allowed Charges are not applied toward the deductible, the stop loss amount or the maximum lifetime benefit.

Creditable Coverage means, with respect to a Federally Eligible Individual, coverage of the individual under any of the following:

- (A) a Group Health Plan;
- (B) health insurance coverage (including group health insurance coverage);
- (C) Medicare;
- (D) Medical Assistance;
- (E) Chapter 55 of Title 10, United States Code;
- (F) a medical care program of the Indian Health Service or of a tribal organization;
- (G) a state health benefits risk pool;

- (H) a health plan offered under Chapter 89 of Title 5, United States Code;
- (I) 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);
- (J) 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 (A) through (J) above that occurred before a break of more than sixty-three (63) days during all of which the individual was not covered under any of items (A) through (J) above. Any period that an individual is in a waiting period for any coverage under a Group Health Plan (or for group 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 more than sixty-three (63) days in any Creditable Coverage;

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.

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.

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.

Federally Eligible Individual means an individual resident of Arkansas:

- (i) (A) for whom, as of the date on which the individual seeks CHIP coverage, the aggregate of the periods of Creditable Coverage is eighteen (18) or more months; and
- (B) whose most recent prior Creditable Coverage was under group health insurance coverage offered by an insurer, a Group Health Plan, a Governmental Plan, or a Church Plan (or health insurance coverage offered in connection with any such plans); and
- (ii) who is not eligible for coverage under:
 - (A) a Group Health Plan;
 - (B) Part A or Part B of Medicare; or
 - (C) Medical Assistance, and does not have other health insurance coverage; and
- (iii) with respect to whom the most recent coverage within the coverage period described in paragraph (i)(A) of this definition was not terminated based upon a factor related to nonpayment of premiums or fraud; and
- (iv) who was offered the option of Continuation Coverage under a COBRA continuation provision or a similar state law and the individual has both elected and exhausted (or soon will exhaust) all rights to such Continuation Coverage.

Governmental Plan has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

Group Health Plan has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

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.

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.

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**.

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

The **Insured Person** is the person whose application is accepted by us and in whose name this Policy is issued and who continues to satisfy the **Eligibility for Enrollment** requirements as outlined in the GENERAL PROVISIONS section of this Policy.

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.

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

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:

- (i) is investigational, experimental, or for research purposes; or
- (ii) is provided solely for the convenience of the Insured Person, the Insured Person's family, physician, Hospital, or any other Provider; or
- (iii) exceeds in scope, duration, or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or
- (iv) could have been omitted without adversely affecting the Insured Person's condition or the quality of medical care; and
- (v) involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration.

An **Out of Network Facility or Out of Network Provider (Out of Network Facility/Provider)** is a Hospital, Skilled Nursing Facility or Provider who does not have an effective contract with the **ADMINISTRATOR**. If an Insured Person receives care from such a Facility or Provider, the Insured Person may be liable for charges in addition to the deductible and co-insurance required by this Policy.

Precertification is the process used to evaluate the medical appropriateness of proposed treatment, and the method by which the treatment will be provided.

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

- 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;

- A registered nurse or licensed practical nurse (see Provider Services in the Covered Expenses section);
- A physical therapist (see Provider Services in the Covered Expenses section).
- Any other person or entity licensed by the state of Arkansas to furnish medical care, services, supplies, drugs, or articles.

A **Resident Eligible Person** means a person who has been legally domiciled in the state of Arkansas for a period of at least thirty (30) days and continues to be domiciled in Arkansas.

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.

Reasonable Charge or Allowed Charge means the amount deemed by the **ADMINISTRATOR**, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Reasonable Charge. However, this charge may vary, given the facts of the case and the opinion of the **ADMINISTRATOR's** medical director.

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.

SCHEDULE OF BENEFITS

The following Schedule is a brief listing of the benefits of this Policy for Medically Necessary services, supplies, drugs, or articles provided to an Insured Person. The rest of this Policy describes in detail the benefits, exclusions, limitations and other Policy provisions.

<u>BENEFIT DESCRIPTION</u>	<u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>	<u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>
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Hospital Inpatient Care

(See Precertification in GENERAL LIMITATIONS.)

• Number of days per stay	Unlimited	Unlimited
• Semi-private room and additional Medically Necessary Hospital care	80%/100%	60%/80%
• Intensive care/coronary care unit	80%/100%	60%/80%

Skilled Nursing Facility Care

(See Precertification in GENERAL LIMITATIONS.)

• Number of days	Up to 120 days each calendar year	Up to 120 days each calendar year
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Outpatient Care

• Outpatient surgery	80%/100%	60%/80%
• Medical Emergency	80%/100%	80%/100%

<u>BENEFIT DESCRIPTION</u>	<u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>	<u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>
<u>Outpatient Care</u> , continued		
• Ambulatory surgical facility	80%/100%	60%/80%
• Non-emergency care	80%/100%	60%/80%
• X-ray/radium therapy, Chemotherapy	80%/100%	60%/80%
• Diagnostic x-ray and laboratory (For accident, illness and pre-admission testing.)	80%/100%	60%/80%
• Imaging and invasive diagnostic	80%/100%	60%/80%
• Residential care for chemical and drug dependency (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%
• Residential care for mental and nervous disorders (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%

Provider Care

• Home and office visits (For accident or illness.)	80%/100%	60%/80%
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<u>BENEFIT DESCRIPTION</u>	<u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>	<u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>
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Provider Care, continued

• Visits and consultations in Hospital	80%/100%	60%/80%
• Surgery (Surgeon, assistant surgeon, anesthesiologist and supplies.)	80%/100%	60%/80%
• Diagnostic x-ray and laboratory (For accident or illness.)	80%/100%	60%/80%
• Outpatient treatment of chemical and drug dependency (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%
• Outpatient treatment of mental and nervous disorders (Limited to the \$4,000 maximum annual benefit per Insured Person.)	50%	50%

Other Services, Supplies, Drugs, and Articles

• Ambulance Services	80%/100%	60%/80%
• Supplies, appliances and Durable Medical Equipment	80%/100%	60%/80%
• Prescription drugs	80%/100%	60%/80%

<u>BENEFIT DESCRIPTION</u>	<u>IN-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>	<u>OUT-NETWORK PERCENTAGE OF ALLOWED CHARGE PAID</u>
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Other Services and Supplies, continued

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| <ul style="list-style-type: none"> • Home health care (Up to 270 visits by RN and LPN per calendar year. See Precertification in GENERAL LIMITATIONS) | 80%/100% | 60%/80% |
| <ul style="list-style-type: none"> • Diabetes Self-Management Training (one lifetime benefit) as prescribed by a physician | 80%/100% | 60%/80% |
| <ul style="list-style-type: none"> • Equipment, supplies, and services for treatment of Type I, Type II, and Gestational Diabetes, as prescribed by a physician | 80%/100% | 60%/80% |

Maximum Lifetime Benefit (per Insured Person) \$1,000,000

The maximum lifetime benefit will be reduced by benefits paid under a prior CHIP Policy.

BENEFITS

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.

IMPORTANT NOTE: To receive full Policy benefits, you must follow the **Precertification** provision in the GENERAL LIMITATIONS section. In addition, it is extremely important to use an In-Network Facility 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 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.

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.

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. The deductible applies separately to each Insured Person.

Stop Loss Amount

After the deductible is satisfied, we will pay Covered Expenses of an Insured Person at the In-Network or Out of Network co-insurance percentage for each service, supply, drug, or article listed in the SCHEDULE OF BENEFITS, depending upon whether the service, supply, drug, or article is rendered by an In-Network or Out of Network Provider. Once Covered Expenses for In-Network services, supplies, drugs, or articles exceed the Stop Loss Amount, subject to the exclusions and limitations set forth in this Policy, we will pay 100% of Covered Expenses for In-Network services, supplies, drugs, or articles and 80% for Out of

Network services, supplies, drugs, or articles incurred during the balance of the calendar year. Benefit reductions made for failure to gain Precertification will not be included in the calculation of the Stop Loss Amount.

- (A) No Covered Expenses paid for treatment of chemical and drug dependency and treatment of mental and nervous disorders shall be eligible for the stop loss provision of this Policy. All Allowed Charges incurred for the treatment of such conditions shall be subject to the General Limitations of this Policy.
- (B) Benefit reductions made for failure to gain pre-certification are not eligible for stop loss.

Out-of-Pocket Maximum Expense

An Insured Person's maximum annual out-of-pocket expense is limited to the annual deductible amount specified in the Coverage Summary plus 20% of the Covered Expenses, provided the Insured Person obtains services, supplies, drugs, or articles from only an In-Network Facility/Provider. If an Insured Person uses only the services, supplies, drugs, or articles of an Out of Network Facility/Provider, because the expenses associated with such services, supplies, drugs, or articles do not accumulate to the Stop Loss Amount, the Insured Person's annual out-of-pocket expense shall be the deductible plus 40% of the Covered Expenses.

Also, it is important to keep in mind that an Insured Person may have to pay the difference between the benefits paid by this Policy and the amount of an Out of Network Facility/Provider bill. In-Network Facilities/Providers have contracted with the **ADMINISTRATOR** to not charge an Insured Person beyond the deductible and co-insurance amounts for Covered Expenses. Out of Network Facilities/Providers, however, may bill an Insured Person for balances over the CHIP payment level in addition to the deductible and co-insurance amount.

COVERED EXPENSES

Hospital Care

(See Precertification in GENERAL LIMITATIONS.)

Care provided by a Hospital. The benefits are explained below.

Hospitalization must be authorized by a physician and must be Medically Necessary for acute care and treatment of an Illness or Injury.

Hospital Benefits. Covered Expenses consist of the following (the level of payment is listed in the SCHEDULE OF BENEFITS):

- The Allowed Charge for a semi-private room or billed charges, whichever is less.
- 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.
- 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.
- The facility charges for surgery performed in a Hospital outpatient department.
- 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.

Emergency and Out-of-State Hospital Admission. If an Insured Person's medical condition necessitates a Medical Emergency (see DEFINITIONS section) 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.

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.

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.

Emergency Room Care. Benefits for care received in a Hospital emergency room are:

- **Medical Emergency:** If the Insured Person receives treatment for a Medical Emergency(see DEFINITIONS section) in the emergency room of any Hospital, Covered Expenses will be paid at the percentage shown in the SCHEDULE OF BENEFITS after the deductible.
- **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 the SCHEDULE OF BENEFITS after the deductible.

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

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.

Skilled Nursing Facility Care (See Precertification in GENERAL LIMITATIONS). 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.

Skilled Nursing Facility Benefits. 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.

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:

- Senile deterioration;
- Mental deficiency or retardation; or
- Mental Illness.

Covered Expenses for Skilled Nursing Facility care DO NOT include routine nursing care, non-medical self-help or training, personal hygiene or Custodial Care.

Home Health Care. This Policy provides benefits for the services of a certified home health agency. The Insured Person's 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.

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.

Provider Services. Care received from certain s must meet specific criteria as described below.

- **Physician.** This Policy covers services, supplies, drugs, or articles rendered by a physician for professional services for diagnosis or treatment of injuries, illnesses or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction.
- **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.
- **RN or LPN.** This Policy covers services rendered by an RN or LPN upon the written referral of a physician if those services are customarily billed to Insured Persons by nurses.
- **Therapists.** This Policy covers services of physical therapists as ordered by a physician.

Services of a Provider are explained below.

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.

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.

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

- The primary surgeon;
- One assistant surgeon;
- The anesthesiologist or certified anesthetist; and includes
- Surgical supplies such as sutures and sterile setups when surgery is performed in the physician's office.

High Dose Chemotherapy is excluded except for specified treatments (See GENERAL EXCLUSIONS).

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.

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.

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.

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

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.

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.

Other Services and Supplies

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.

Prescription Drugs. Covered Expenses include insulin and drugs or medications that relate directly to the treatment of an Illness or Injury that cannot legally be dispensed without a physician's prescription, and that by law must bear the legend "Caution - Federal law prohibits dispensing without prescription." This Policy does not cover contraceptive drugs or devices, or fertility or weight loss drugs or compound drugs.

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:

- 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);
- Prosthetics (other than dental);
- Casts, trusses, limb or back bones and crutches;

- 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;
- 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;
- Oxygen; and
- Equipment, supplies and services for treatment of Type I, Type II, and gestational diabetes as prescribed by a physician.

Special Dental Care. Covered Expenses include 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.

GENERAL LIMITATIONS

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.

Pre-existing Condition Exclusions

• **Not Covered Expenses.** Except for Federally Eligible Individuals qualifying for CHIP coverage or Resident Eligible Persons who qualify for and elect to purchase the conditional waiver as described below, the Insured Person's coverage under this Policy will not include as Covered Expenses those incurred during the first six (6) months following the effective date of coverage as to any condition if:

- (1) The condition has manifested itself within the six (6) month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment; or
- (2) Medical advice, care or treatment was recommended or received within the six (6) month period immediately preceding the effective date of the coverage.

• **Conditional Waiver.** If the optional conditional waiver is purchased, the preexisting condition exclusion will be waived if the Resident Eligible Person:

- (1) Has satisfied similar exclusions and had six months of coverage under any prior health insurance or Group Health Plan that was involuntarily terminated;
- (2) Is ineligible for any Continuation Coverage that would continue or provide substantially similar coverage following that termination; and
- (3) Has applied for CHIP coverage not later than thirty (30) days following the involuntary termination.

For each Resident Eligible Persons who qualifies for and elects the Pre-existing Condition Exclusion Waiver, there shall be added to each payment of premium, on a pro-rated basis, a surcharge of 10% of the otherwise applicable annual premium for as long as that individual's coverage under CHIP remains in effect or sixty (60) months whichever is less.

- **Subrogation.** 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.

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.

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.

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

Precertification

How to Precertify. Precertification 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. An In-Network Facility/Provider will Precertify 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 Precertification authorization. Failure to obtain Precertification may result in an additional reduction of benefits of \$200. Benefits will be denied for services, supplies, drugs, or articles which are not Medically Necessary (see 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.

Chemical and Drug Dependency

Covered Expenses for treatment of chemical and drug dependency, including prescription 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.

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.

Transplantation

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:

Definitions. In addition to the definitions in the DEFINITIONS section, the following definitions apply to this limitation.

Covered Transplant means medically appropriate transplant of

heart;

heart/lung or lung;

kidney;

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

liver;

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 the GENERAL EXCLUSIONS section.

- A **Transplant** means a procedure or a series of procedures by which an organ or tissue is either:
 - * removed from the body of one person (called a **Donor**) and implanted in the body of another person (called the **Recipient**); or
 - * removed from and replaced in the same person's body (called a **Self-Donor**).

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

- **Donor Costs** means the reasonable cost of :
 - * medical services required to remove the organ or tissue from the Donor's or Self-Donor's body;
 - * preserving it; and
 - * 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.

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

Benefits. Benefits for Covered Transplants are payable up to the maximum lifetime benefit as follows:

- **Facility Benefits.** We will pay for facility Transplant services according to the benefit for “Hospital Care” in the COVERED EXPENSES section of this Policy.
- **Provider Benefits.** We will pay for Provider Transplant services according to the benefit for “Provider Services” in the COVERED EXPENSES section of this Policy.
- **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.

- **Antirejection Drug Benefits.** We will pay according to the prescription drug benefit under this Policy for antirejection drugs following the Covered Transplant.
- **Preauthorization Requirement.** 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.

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.

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.

Exclusions. In addition to the exclusions listed in the GENERAL EXCLUSIONS section, we will not pay for the following:

- Donation related services, supplies, drugs, 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;
- Services, supplies, drugs, 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;
- 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.

GENERAL EXCLUSIONS

We will not pay for the following:

High Dose Chemotherapy. 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, drugs, or articles associated with High Dose Chemotherapy and related procedures will be covered are in the following limited circumstances:

- (1) For a diagnosis of Non-Hodgkin's lymphoma, when classified as intermediate or high grade stage III, or stage IV;
- (2) For a diagnosis of Hodgkin's disease, when classified as stage IIIA, IIIB, IVA or IVB;
- (3) For a diagnosis of neuroblastoma, when classified as stage III or stage IV;
- (4) For a diagnosis of acute lymphocytic or non-lymphocytic leukemia following a first or any subsequent relapse;
- (5) 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 (a) patients with advanced disease who fail to achieve a complete response to second-line therapy, and (b) 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;
- (6) For a diagnosis of metastatic breast cancer with (a) metastatic breast cancer patients who have not been previously treated with systemic Chemotherapy for metastatic disease; (b) metastatic breast cancer that is

responding to primary systemic therapy; or (c) 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;

- (7) 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.)
- (8) 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;
- (9) For children or young adults up to thirty-two (32) years of age with metastatic Ewing's sarcoma.

In each of the nine (9) limited cases outlined 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.

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, drugs, 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:

1. the acceptable donor matches patient at all six HLA antigens, and patient and donor cells are nonreactive in mixed leukocyte culture:
 - a. aplastic anemia;
 - b. Wiskott-Aldrich syndrome;
 - c. infantile malignant osteoporosis (Albers-Schonberg syndrome or marble bone disease);
 - d. homozygous beta-thalassemia (thalassemia major); or
 - e. 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);

2. acceptable donor matches the patient at three or more of six HLA antigens, and patient and donor cells are nonreactive in mixed leukocyte culture:
 - a. severe combined immunodeficiency syndrome (e.g. adenosine deaminase deficiency and idiopathic deficiencies);

3. 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:
 - a. non-Hodgkin's lymphoma, intermediate or high grade stage III or stage IV;
 - b. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB;
 - c. Neuroblastoma, stage III or stage IV; or

- d. chronic myelogenous leukemia in blast crisis or chronic phase.
4. 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:
- a. 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:
 - (1) age greater than 15 years;
 - (2) leukocyte count greater than 10×10^9 per liter;
 - (3) extramedullary disease (especially central nervous system disease);
 - (4) leukemic blast and chromosomal translocations; and
 - (5) failure to achieve a complete remission within six weeks of the start of induction therapy; or
 - b. chronic myelogenous leukemia in chronic phase;
5. multiple Myeloma in patients under the age of 55 years when performed with an HLA-matched donor.

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

Treatments for Admissions Prior to Coverage. Services, supplies, 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.

Services, Supplies, Drugs, or Articles Provided by a Member of Your Immediate Family.

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.

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:

- Routine physical, mental or eye examinations;
- Routine tests and screening procedures, except routine Hospital pre-admission testing;
- The fitting, provision or replacement of eyeglasses and hearing aids;
- Telephone consultants, missed appointment, completion of claim forms or completion of reports requested by us in order to process claims;
- 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;
- Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition;
- 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
- Personal items, such as telephone, televisions and guest meals, in a Hospital or Skilled Nursing Facility.

Eye Exercises.

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

Private Nursing Service for Hospital inpatients is excluded.

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);

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.

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

Massage or Massage Therapy.

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

Orthopedic Shoes.

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.

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.

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.

In Vitro Fertilization is excluded.

Dental Examinations and Treatments are excluded, except as specifically provided in the **Special Dental Care** subsection of the COVERED EXPENSES section. 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.

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

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

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

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.

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.

Occupational, Speech, and Audiological Therapy is excluded.

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.

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 drug, 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 defined 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 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.

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.

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.

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 the **Third Party Liability** subsection in the GENERAL PROVISIONS section.

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 the **Motor Vehicles Coverage** subsection in the GENERAL PROVISIONS section.

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 the **Workers' Compensation** subsection in the GENERAL PROVISIONS section.

Services Otherwise Available are excluded. This category includes:

- 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;
- 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;

- Services, supplies, drugs, or articles for which no charge is made, or for which no charge is normally made in the absence of insurance;
- Medicare and Medicaid or other Medical Assistance plans. 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.

Charges Over Benefits Authorized Under This Policy are excluded.

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

GENERAL PROVISIONS

When Coverage Begins

Coverage begins on the first of the month after we have accepted and approved your application for enrollment, and the applicable premium has been paid.

Any person whose previous health insurance was involuntarily terminated for any reason other than nonpayment of premium or fraud and who applies for coverage under this Policy within sixty (60) days after the involuntary termination of such previous health insurance coverage will have effective coverage under this Policy as of the date of the termination of the previous coverage if the applicable premium is paid for the entire period of coverage.

Eligibility For Enrollment

I. RESIDENT ELIGIBLE PERSON

In order to be eligible for coverage under this Policy as a Resident Eligible Persons (see DEFINITIONS Section), you must be either a citizen of the United States or an alien lawfully admitted for permanent residency and you must have been legally domiciled in the state of Arkansas for a period of at least thirty (30) consecutive days prior to your application for coverage under this Policy.

No person is eligible for coverage under this Policy as a Resident Eligible Persons:

- (A) unless such person has provided evidence to the **ADMINISTRATOR** of:
 - (i) a notice of rejection or refusal by an insurer to issue substantially similar individual health insurance coverage by reason of the existence or history of a medical condition; or
 - (ii) 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;

- (iii) A rejection or refusal by a Group Health Plan or insurer offering only Excess or Stop Loss Coverage or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence hereunder.
- (B) who has or obtains other health insurance coverage substantially similar to or more comprehensive than this CHIP Policy or would be eligible to have coverage, including coverage under a Group Health Plan, Part A or B of Medicare or Medical Assistance, if the person elected to obtain such coverage, except that a Resident Eligible Persons:
 - (i) may maintain other coverage for the period of time such person is satisfying any pre-existing condition waiting period under this Policy; and
 - (ii) 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 Policy intended to replace this Policy.
- (C) who has previously terminated CHIP coverage unless twelve (12) months have elapsed since termination of CHIP coverage.
- (D) who fails to pay the required premium under this Policy 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 the Insured Person remained eligible for coverage under this Policy.
- (E) if on whose behalf this Policy or a prior CHIP policy has paid out a total of \$1,000,000 in Covered Expenses or benefits of any kind.
- (F) who is a resident of a public institution.
- (G) whose premium is paid for or reimbursed under any governmental sponsored program or by any government agency, foundation, or health care Provider, except as an otherwise qualifying full-time employee or

dependent of such an employee of a government agency, foundation or health care Provider.

II. FEDERALLY ELIGIBLE INDIVIDUAL

Notwithstanding the requirements of Subsection I. above, any Federally Eligible Individual (see DEFINITIONS Section) for whom an application and such enclosures and supporting documentation, including acceptable written certification of previous Credible Coverage, as may be required by the **ADMINISTRATOR**, that will establish to the **ADMINISTRATOR'S** satisfaction the applicant meets all the requirements to be a Federally Eligible Individual, that is received by the **ADMINISTRATOR** within sixty-three (63) days after the termination of prior Credible Coverage (for reasons other than nonpayment of premium or fraud), and who is currently and permanently residing in the state of Arkansas shall be eligible for coverage under this Policy

No person is eligible for coverage under this Policy as a Federally Eligible Individual if such person:

- (A) is eligible for coverage under any of the following:
 - (i) a Group Health Plan;
 - (ii) Part A or B of Medicare; or
 - (iii) Medical Assistance from the Arkansas Medicaid program.
- (B) has other health insurance coverage.
- (C) had his/her previous Credible Coverage, that was in force for eighteen (18) or more months, terminated based upon a fact or relating to nonpayment of premium or fraud.
- (D) has been offered, elected and has not exhausted (or soon will exhaust) all rights he/she may have to Continuation Coverage under COBRA or any similar state continuation laws.

- (E) on whose behalf this Policy or a prior CHIP Policy has paid out a total of \$1,000,000 in Covered Expenses or benefits of any kind.
- (F) fails to pay the required premium under this Policy 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 the Insured Person remained eligible for coverage under this Policy.
- (G) a Federally Eligible Individual who qualifies and enrolls in the plan pursuant to this Subsection II must satisfy and continue to satisfy all of the other eligibility and Policy requirements of the GENERAL PROVISIONS including the provisions of Subsection I, II, and III of the GENERAL PROVISIONS to the extent such provisions are not inconsistent with the federal Health Insurance Portability and Accountability Act of 1996, as amended, in order to maintain continued eligibility for coverage under this Policy.

III. ALL PERSONS

The following provisions apply to all Insured Persons:

Newborn Children

In the event an Insured Person becomes the natural parent of a Newborn Child, the Newborn Child will be issued a CHIP Policy providing coverage from the date of birth if (1) the Insured Person submits an application on behalf of his/her Newborn Child within thirty-one (31) days of the date of the child's birth, (2) the premium for the Newborn's CHIP Policy is paid when the Policy is issued, (3) the Newborn Child is not eligible for any other health benefits coverage whether insured, self insured or a governmental program, and (4) the Newborn Child is a resident of the State of Arkansas.

Premiums

The initial premium you must pay is shown on the Coverage Summary which comes with this Policy, or is issued thereafter. Further premium payments will be billed to you and payable in accordance with the premium payment mode you select.

Methods of Payment. You have two options with which to pay premiums. We will accept monthly payments if they are paid by automatic transfer from a checking account or from a list bill. A list billing allows an employer to withhold the applicable premium from an employee's earnings and submit the premium payment to the **ADMINISTRATOR** pursuant to a direct premium billing to the employer. Otherwise, you may make payments every three months. If automatic transfer from your bank is interrupted for any reason, replacement payment must be made at a three-month rate. If you wish to cancel the bank transfers, we must receive written notice no less than fifteen (15) days before the next transfer date.

When Payments Are Due. Premium payments are due in advance for all payment methods. We will allow you a 10-day grace period after the premium due date if the payments are made monthly by automatic transfer from a checking account. If you are paying every three months, the grace period is thirty-one (31) days. If you do not make the payment within the grace period, this Policy will end without notice. Your coverage will end on the last day of the monthly coverage period for which premiums were paid. Your monthly coverage period is the first to the last day of the month.

This Policy is renewed each time you make a premium payment. If your payments are made monthly by automatic transfer from a checking account, this Policy is renewed for one month. If you pay every three (3) months, it is renewed for three (3) months.

Changes in Premium Rate. Your premium is age rated. This means the premium will always increase on the next premium due date you reach age 20, 25, 30 or 35, etc. We will give you thirty-one (31) days written notice before we increase your premium for age or for any other reason. If you pay the new rate, the payment indicates that you accept the change. If you do not accept the change, you can automatically terminate this Policy by not paying the new rate.

When this Policy Ends

The coverage provided under this Policy shall terminate at the end of the monthly coverage period for any person who ceases to meet the eligibility requirements of this Section unless a person ceases to be a resident of the state of Arkansas in

which case coverage shall terminate on the date such person is no longer a resident of the state of Arkansas.

There are circumstances other than failure to pay premiums that will cause the coverage under this Policy to terminate immediately without notice. These are described in the following paragraphs.

If You Terminate. You may terminate this Policy at any date during any period for which you have paid premiums by giving us thirty-one (31) days prior written notice of the date you wish to terminate coverage or you may terminate by simply not paying your premiums for the next term. If you wish to cancel your automatic transfer from a checking account, please see the **Methods of Payment** subsection of the PREMIUMS section of this Policy.

If We Terminate. This Policy is renewable except as follows:

- This Policy will terminate automatically without notice at the end of the current monthly coverage period for which you have paid premium if, during that monthly coverage period, you:
 - * have or obtain health insurance coverage substantially similar to or more comprehensive than this Policy or you would be eligible to have health insurance coverage if you elected to obtain it (NOTE: This provision does not apply to a Federally Eligible Individual unless such person has other health insurance coverage or is eligible for coverage under a Group Health Plan, 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 Policy intended to replace this Policy;

- * have failed to pay the required premium under this Policy 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;
 - * have received a total of \$1,000,000 in CHIP benefits during your lifetime;
 - * have previously terminated CHIP coverage unless twelve (12) months have elapsed since termination of CHIP coverage (NOTE: This provision does not apply to a Federally Eligible Individual);
 - * are a resident of a public institution (NOTE: This provision does not apply to a Federally Eligible Individual);
 - * had your premium paid for or reimbursed under any government sponsored program or by any government agency, foundation, or health care Provider, except as an otherwise qualifying full-time employee or dependent of such employee of a government agency, foundation or health care Provider (NOTE: This provision does not apply to a Federally Eligible Individual);
- This Policy will terminate automatically without notice:
 - * on the date you are no longer a resident of the state of Arkansas;
 - * on the date you request coverage to end;
 - * on the date of your death;
 - * on the date Arkansas law requires cancellation of this Policy; or
 - * at CHIP's option, thirty (30) days after CHIP makes any written inquiry concerning your eligibility or place of residency to which you do not reply.

- This Policy may be rescinded if you made a material misstatement or omission on your application.

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.

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.

Medicare/Medicaid. We will not duplicate benefits payable through or by Medicare or Medicaid for an Insured Person who is enrolled in Medicare or Medicaid.

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:

- 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:
 - * to give us information about any motor vehicle insurance coverage which may be available to you; and
 - * to hold the proceeds of any recovery from motor vehicle insurance in trust for us and reimburse us as provided below.

- 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.
- 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).
- 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.

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:

- 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.
- 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.

- 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:
 - * the recovery is the result of a court judgment, arbitration award, compromise settlement or any other arrangement;
 - * the third party or the third party's insurer admits liability; or
 - * the health care expenses are itemized or expressly excluded in the third-party recovery.

- 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.

- 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.

The “net recovery amount” is calculated as follows:

Gross Recovery

Amount of Recovery ¹
 Amount of Other Source of Recovery ²
 Total Gross Recovery Amount ³

Deductions from Gross Recovery

Unpaid Claims ⁴
 Reimbursement from Recovery Funds ⁵
 Cost of Recovery Action ⁶
 Total Deductions from Gross Recovery ⁷

Net Recovery ⁸

Notes:

- 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.

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:

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

- * 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.
- 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.
- 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:
 - * the recovery is the result of an arbitration award, compromise settlement or any other arrangement;
 - * the entity providing workers' compensation coverages admits liability; or
 - * the health care expenses are itemized or expressly excluded in the recovery.
- 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.
- 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 (as defined in the "Third Party Liability" provision).

Duplication of Benefits

Benefits payable through the Arkansas Comprehensive Health Insurance Pool (CHIP) are reduced by amounts payable through any other health insurance, self-

insurance arrangement, or other coverage providing Hospital and Provider benefits. CHIP does not duplicate benefits paid through another plan.

Determining Continued Medical Necessity

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.

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.

Alternative Services

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:

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

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.

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.

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.

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.

When Benefits Are Available

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

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

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.

Submission and Payment of Claims

In most 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:

- A Provider bills you directly;
- A Hospital bills you directly;
- A Provider of other services, supplies, drugs, or articles bills you directly;
or

- You receive care from a Provider or facility located outside of Arkansas.

In these cases, 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:

- Your name (the patient) and identification numbers;
- A description of the symptoms that were observed or a diagnosis; and
- A description of the services, supplies, drugs, or articles and the dates on which they were given.

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.

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.

When You Must Submit 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 **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.

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.

Claims Appeal. 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 of Arkansas, 320 W. Capitol Avenue, Suite 500, Little Rock, Arkansas 72201 or P.O. Box 1460, Little Rock, Arkansas 72203-1460. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. However, medical information can be released to you only upon the written authorization of your physician. 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.

If you are still not satisfied at this point, you have the right to file a final appeal with the Board of the Arkansas Comprehensive Health Insurance Pool.

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.

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.

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.

Changing This Policy

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.

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

OR

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

Michael D. Wilkinson, Chairman
Arkansas Comprehensive Health Insurance Pool