RESPONSE TO

SOLICITATION FOR STATE PROPOSALS TO OPERATE QUALIFIED HIGH RISK POOLS

STATE OF ILLINOIS

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Illinois Department of Insurance

PAT QUINN
Governor

Michael T. McRaith
Director

I, Michael T. McRaith, Director, Illinois Department of Insurance, attest to the following:

I have read the contents of the completed proposal and the information contained herein is true, correct, and complete. If I become aware of any information in this proposal that is not true, correct, or complete, I agree to notify the Department of Health and Human Services ("HHS") immediately and in writing.

I authorize HHS to verify the information contained herein. I agree to notify HHS in writing of any changes that may jeopardize my State's ability to meet the qualifications stated in this proposal prior to such change or within 30 days of the effective date of such change.

I agree that if HHS approves this proposal and awards a contract to my State or State's designated high risk pool, that my State or State's designated high risk pool will abide by the requirements contained in the contract and provide the services as outlined in this proposal.

I agree that HHS may inspect any and all information necessary, including inspecting the premises of the high risk pool program's organization or contractors to ensure compliance with Stated Federal requirements. I further agree to immediately notify HHS if, despite these attestations, I become aware of circumstances which preclude full compliance with the requirements stated in this proposal.

I certify that I am authorized to certify this submission on behalf of my State or my State's designated entity.

Michael T. McRaith	Director, Illinois Department of Insurance
Michael McRaith	Director
Authorized Representative Name (printed)	Title
	June 16, 2010
Authorized Representative Signature	Date

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C.4 TECHNICAL APPROACH CONTENT

C.4.1	Administrative Functions
Requirement	Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for enrollees. If the State operates another high risk pool, describe how the State will segregate funding and expenditures for the two programs and track enrollees separately across all benefits and services. If the proposal is to delegate the operation to a nonprofit entity, the State should clearly indicate if it proposes that HHS contract with the State (that will subcontract with the nonprofit) or proposes that HHS contract directly with the nonprofit high risk pool. If the State proposes that HHS contract directly with the nonprofit high risk pool, provide copies of all governing authorities of the nonprofit entity, including statutes, regulations, governance, and plan of operation. As part of the technical approach, the State or its designated entity may subcontract with either a for-profit or nonprofit entity.
Response	Illinois proposes to structure the federally funded Temporary High Risk Pool ("THRP") in a manner similar to the existing high risk pools currently

C.4.1	Administrative Functions

administered in Illinois. Illinois proposes to draw upon existing resources and expertise to administer the program.

See Appendix A: Illinois CHIP Summary of Coverage.

Illinois intends that the THRP will begin processing enrollment applications shortly after acceptance of this proposal by HHS, after entry by Illinois into a contract with HHS, and after completion of the statutory procurement process. Coverage would commence shortly thereafter.

Financial Structure

Illinois proposes to establish a new pool which will be identified with independent, unique member/parent group I.D. numbers and separate group/section numbers in order to monitor closely and manage revenues and expenditures. Funding, expenditures, management, and administration of the THRP will be entirely separate and distinct from any other similar health insurance pool. Illinois would not receive or expend funds for the purpose of claims payment. Illinois proposes that all payments and expenses directly attributable to the THRP, including but not limited to claim expenses, third party administrator fees, premium refunds, NSF's, bank fees and agent referral fees, will be paid by HHS directly to those entities that supply those services necessary to operate the THRP. HHS payments will not be made to Illinois.

C.4.2	

In response to the questions below, describe how the State will design a high risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the Statement of Work.

C.4.2 (1)	Eligibility criteria
Requirement	Describe the eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the proposed high risk pool program.
Response	Illinois will require that all applicants to the THRP meet all applicable eligibility requirements: 1. Applicants must be residents of Illinois. 2. Applicants must be United States citizens, nationals, or lawfully present in the United States. 3. Applicants must have one of the listed pre-existing medical conditions. 4. Applicants must have been uninsured for the six (6) months prior to application. Current Illinois law allows health insurers to deny coverage for any reason other than "race, color, religion or national origin." As a result, Illinois health insurers deny coverage for applicants for many reasons that do not medically constitute a pre-existing condition. To determine eligibility, Illinois will use, pursuant to A.4.2.1.c, the list of presumptive medical conditions currently used in the determination of eligibility for its medically uninsurable high risk pool, or as such list is amended for THRP purposes. A person who is a U.S. citizen, national, or lawfully present in the U.S., and has been without creditable coverage for six months, will be eligible for the THRP if he or she has one of the conditions listed. Enrollment will be limited based on federal funding and premiums collected. The Illinois THRP will enroll only those individuals with a preexisting condition to the extent that federal funding would allow that individual continuous enrollment to January 1, 2014. See Appendix A: Summary of Coverage, Page 5.

C.4.2 (2)	Coverage and benefits
Requirement	Describe the coverage and benefits to be offered by the qualified high risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.
Response	Illinois intends to offer one coverage option to THRP participants initially. Depending on claims experience, Illinois will determine whether to make another option available. Illinois will monitor and manage the THRP in a fiscally prudent manner to ensure that all enrollees will be able to receive coverage until January 1, 2014. Since providers generally receive more than 90 days to submit claims for payment, Illinois will create a claim reserve from the federal funds to process provider claims. Based on the experience of existing high risk pools and actuarial assessments, Illinois proposes a Preferred Provider Option (PPO) plan design that will include a deductible of $2,000 per calendar year, with an 80/20 coinsurance and a major medical out-of-pocket limit of $2,350 per year. If a non-PPO provider is used, the member would pay 20% higher coinsurance. Prescription drug benefits would be provided with a 20% copayment, up to an out-of pocket maximum of $1,600. The benefits will be structured such that coinsurance and out-of-pocket will not exceed a combined total of $5,950 per year, consistent with limits set by Section 223(c)(2) of the Internal Revenue Code of 1986 for the relevant year. Current Illinois high risk pools have a lifetime maximum set at $2.0 million. Illinois statute requires the lifetime maximum to reduce to $1.5 million on August 29, 2010. Legislation has passed the Illinois General Assembly and is pending the Governor's signature to increase this lifetime maximum to $5.0 million. For

C.4.2 (2)	Coverage and benefits
	ease of administration, and to facilitate implementation of the THRP, Illinois will, at least for the implementation phase, apply these statutory limits to the THRP. The THRP benefit structure will resemble Illinois' current coverage in the existing HIPAA high risk health pool. Deductibles and the prescription drug out-of-pocket charges will be modified in order to comply with Section 223(c)(2) of the Internal Revenue Code of 1986 for the relevant year. See Appendix A: Summary of Coverage.

C.4.2 (3)	Pre-existing conditions
Requirement	How will the qualified high risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?
Response	Current Illinois law allows health insurers to deny coverage for any reason other than "race, color, religion or national origin." As a result, Illinois health insurers deny coverage for applicants for many reasons that do not medically constitute a pre-existing condition. Illinois will not deny enrollment, or impose coverage limitations, in the THRP based on a pre-existing condition. The Illinois THRP will enroll only those individuals with a presumptive pre-existing condition to the extent that federal funding would allow that individual continuous enrollment to January 1, 2014.

C.4.2 (4)	Premiums and standard risk rate
Requirement	Describe how the qualified high risk pool will derive its premiums, including a

C.4.2 (4)	Premiums and standard risk rate
	description of its methodology in determining the standard risk rate.
Response	A consulting actuary will prepare a premium rate recommendation using the following methods: *Calculation of the standard risk rate* Illinois proposes to survey insurance companies writing individual health insurance policies in Illinois twice a year. Illinois will determine a standard risk rate by averaging the premium rates charged for similar benefits and cost-sharing by at least five of the largest insurers offering health insurance coverage to individuals in Illinois. The standard risk rate will be established using reasonable actuarial techniques. *Determination of pool premiums* The premiums charged under the THRP will not exceed 100 percent of the standard risk rate in Illinois. Premiums charged to enrollees in this pool will vary on the basis of age by a factor not greater than 4 to 1. The consulting actuary's premium rate recommendation will be independently reviewed and adjusted as needed.

C.4.2 (5)	Cost sharing structure
Requirement	Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high risk pool that complies with the requirements outlined in A.4.2.7.
Response	Illinois proposes a cost sharing structured benefit package such that coinsurance and out-of-pocket will not exceed a combined total of $5,950 per year, consistent

C.4.2 (5)	Cost sharing structure
	with limits set in Section 223(c)(2) of the Internal Revenue Code of 1986 for the relevant year. Illinois proposes a benefit plan consisting of a $2,000 deductible, with 80% / 20% coinsurance. Prescription drug benefits would be provided with a 20% copayment, up to an out-of pocket maximum of $1,600. Based on an actuarial calculation made by Blue Cross/Blue Shield of Illinois, plan administrator for Illinois' existing high risk pools, the THRP's share of the total allowed cost of the benefits provided would be approximately 68%. See Appendix E: Actuarial Attestation.

C.4.2 (6)	Provider networks
Requirement	If applicable, describe the provider network(s) proposed to be used by qualified high risk pool enrollees and demonstrate that the network(s) has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible in those networks.
Response	Illinois intends to utilize network relationships similar to those currently serving the participants in existing high risk pools, or administrators with similar capabilities and pricing levels. The plan administrator for current pools is Blue Cross and Blue Shield of Illinois (BCSBIL), and the current Pharmacy Benefit Manager (PBM) is Walgreens Health Initiatives (WHI). Even though BCBSIL and WHI were identified in reply to a formal procurement process for the existing high risk pools, Illinois will issue a new request for proposal to identify a plan administrator and PBM for the THRP. Illinois will issue an RFP for medical and pharmaceutical claim services to secure vendors that have appropriate networks of providers with a strong presence in Illinois from which THRP enrollees will be able to obtain services.

C.4.2 (7)	Appeals and reconsiderations process
Requirement	Describe the appeals and reconsiderations process that the qualified high risk pool proposes to make available to enrollees in the high risk pool program as per the description of section A.4.2.10.
Response	Illinois proposes addressing appeals and reconsiderations that may arise in the THRP in a manner similar to that utilized in our existing high risk pool. The appeals procedures will provide enrollees and potential enrollees the right to a timely redetermination of eligibility or coverage by the THRP or its designee. Enrollees and potential enrollees will also have the right to a timely reconsideration of a coverage redetermination by an entity independent of the THRP. Attached is a copy of Illinois' current high risk pool appeals process, which will be adapted to meet the RFP's requirements. See Appendix C: Illinois CHIP Grievance Procedures.

C.4.3	Eligibility determination and enrollment standards
Requirement	Describe the qualified high risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.
Response	These standards are fully described by the answers to subsections C.4.3(1) – C.4.3(5).

C.4.3 (1)	Eligibility determination process
Requirement	How will the qualified high risk pool develop and utilize an eligibility determination process that will assure that only individuals eligible for coverage, as described in Section A.4.2 of the Statement of Work, receive benefits from the program?
Response	Illinois will utilize experienced professionals to determine eligibility and collect premiums. Trained individuals will assist with review of ongoing eligibility issues. The Illinois application will require the following: 1. Applicant must provide a copy of IL driver's license, Identification Card, or most recent year IL tax return to verify Illinois residency. 2. Applicant must provide a copy of birth certificate, Certificate of Naturalization, Green Card (I-551), or other documentation which verifies lawful presence in the United States. 3. Applicant must submit physician verification of the applicant's presumptive condition on a prescribed form. 4. Applicant must submit verification of uninsured status for the six (6) months prior to application. Applications will be reviewed by trained individuals to verify that documentation received meets the eligibility criteria.

C.4.3 (2)	Information
Requirement	How will the qualified high risk pool obtain all of the information described in Section A.4.2 of the Statement of Work as part of the proposal process in the high risk pool program?
Response	During review of documentation received, if additional documentation is required, THRP staff will contact applicants to request any missing information.

C.4.3 (3)	Confirmation of citizen, national, or lawful alien status
Requirement	Describe the process that the qualified high risk pool will use to confirm that an enrollee is a citizen or national of the United States or an alien lawfully present in the United States.
Response	A copy of a birth certificate, Certificate of Naturalization, Green Card (I-551), or other documentation will be required to verify lawful presence in the United States.

C.4.3 (4)	Enrollment process
Requirement	Describe the enrollment process that the qualified high risk pool proposes to use.

C.4.3 (4)	Enrollment process
Response	Applications received will be entered into the system and then assigned to an examiner. The examiner will review the application file to determine if eligibility criteria have been met. If documentation has not been submitted with the application, the examiner will contact the applicant to request the missing documentation. The application requires proof that the applicant resides in Illinois, verification of U.S. Citizenship (*i.e.*, birth certificate or certification of naturalization), proof of Green Card (I-551), or other documentation which verifies the applicant is lawfully present in the United States. To document that the applicant has been uninsured for 6 months prior to date of application, the THRP will require documentation from each employer listed on the application verifying that health insurance has not been offered to employees or the reason(s) the person does not qualify for the employer-offered coverage. If coverage has existed within the past 12 months the applicant will be required to submit a "certificate of creditable coverage" that verifies when he or she was last insured. The Illinois THRP will employ other verification mechanisms as available and as needed. Once eligibility has been verified, the applicant will be notified of the opportunity to enroll and the premium for the program will be collected. When a premium payment is received and verified for the correct amount, the application will be processed to activate the participant in the Plan Administrator's system, at which time ID cards and Benefit Plan Booklets will be issued.

C.4.3 (5)	Disenrollment process
Requirement	Describe the disenrollment process that the high risk pool plan proposes to use.
Response	Illinois will supervise the THRP in a fiscally prudent manner to ensure that all enrolled members are able to remain enrolled until January 1, 2014. Enrollment will be limited and managed based on actual claims experience and projected availability of funds. Upon discovery that a member does not reside in Illinois, the member's participation in the THRP will be terminated. Participation will be terminated upon discovery that a member is eligible for Medicare or Medicaid. Multiple methods are used to discover ineligibility: • The plan administrator's claims system identifies potential cases of overlapping coverage. • Illinois conducts periodic continued eligibility investigations. • Illinois will use a monthly data match with the Illinois Medicaid Agency to check for overlapping coverage. Coverage will terminate on the earliest of: 1. The date a member is no longer a United States citizen or lawfully present in the United States. 2. The date the participant is no longer a resident of Illinois. 3. The date the participant became ineligible for the THRP coverage under state or federal law. 4. The date the participant's THRP coverage otherwise ends due to nonpayment of the required renewal premium. 5. The date the participant requests THRP coverage to end, provided the written request is received prior to such date. 6. The date THRP coverage of all covered persons within the same class,

C.4.3 (5)	Disenrollment process
	form or benefit plan as the participant is terminated. 7. The date of the participant's death.

C.4.4	Customer service functions and standards
Requirement	Describe the customer service functions and standards that will be employed by the qualified high risk pool program. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide to enrollees in the qualified high risk pool.
Response	Illinois or the plan administrator will utilize a Customer Services Unit that routes all incoming calls to the appropriate unit and/or person in the office; to the administrative unit of the plan administrator; or to the pharmacy benefit manager. Illinois or the plan administrator will use trained staff to answer incoming calls from prospective participants. Hours of operation will be 8:00 to 5:00 Central Standard Time, Monday through Friday. Customer Services staff will receive ongoing training regarding the Plan's benefit structure and operational procedures. Any issues the Customer Services staff cannot address are routed to the unit supervisor for resolution. Illinois and/or the plan administrator will operate a customer service call center that is appropriately staffed to the number of plan enrollees so as to provide prompt and accurate information and services to THRP members. Illinois expects

C.4.4	Customer service functions and standards

to utilize approximately 1 customer service representatives (CSR) for every 4,000 members. These CSRs will field all incoming calls from prospective applicants, agents, and other interested parties.

Illinois expects staffing levels to mirror those for its current high risk pool—1 staff member (including CSRs referenced above) for every 500 enrollees. Illinois or the plan administrator will utilize customer service staff who are fluent in languages other than English to meet the needs of the population anticipated to be served by the THRP and will also make customer service and plan enrollment information available in formats that are accessible by people with disabilities. Illinois and/or its administrators will operate a technical support center, which may include both a call center and an electronic/automated system, to respond to health care and pharmacy providers seeking information related to an enrollee's benefits, coverage determinations (including exceptions and prior authorizations) and enrollee appeals. Illinois anticipates that its website will be enhanced to reflect pertinent information about the THRP upon approval of this proposal by HHS.

Current performance standards for Illinois' existing high risk pools are as follows:

Calls = Average speed to answer = 0 - 30 seconds = 85%

Claims Processing = Clean claims within 14 days or less = 90%, within 30 days = 99.5%

Investigated claims within 21 days = 80%, within 60 days = 99.5%

Financial accuracy of claim payments = 98%

Procedural accuracy of claim payments = 98%

Specified complaint response = closed within 14 days = 80%

Step one grievance = closed within 30 days = 100%

Step two grievance = closed within 60 days = 100%

Issuance of enrollment material within 10 days = 99%

C.4.4	Customer service functions and standards

C.4.5	Technical support center
Requirement	Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high risk pool. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide.
Response	*Plan Administrator* Illinois will assure twenty-four hour, seven day a week technical support to network pharmacies through a centralized Customer Care Center. Illinois will provide customers with a single point of accountability for medical claims, inquiries and membership processing.

C.4.6	Billing, collection, and accounting system
Requirement	Describe the qualified high risk pool's system for billing, collecting, and accounting for premiums.
Response	Illinois proposes to use premium billing, collection and accounting procedures similar to the procedures used for the existing high risk pools. Three payment options will be available: monthly automated bank drafts, quarterly invoices and

C.4.6	Billing, collection, and accounting system
	semiannual invoices. The plan administrator will be responsible for the billing and accounting of premiums.

C.4.7	Utilization and care management
Requirement	If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage, describe the utilization and care management processes that the qualified high risk pool proposes to use.
Response	*Plan Administrator* The medical claim administrator will verify coverage, interpret member benefits and perform medical necessity review and approval for both inpatient and outpatient services. The medical claim administrator also will conduct concurrent reviews of inpatient stays, assess the appropriateness and continuing need of services, assess the most appropriate care delivery setting, assess case management needs, and assess the appropriateness of the discharge plan and post-hospitalization needs. *Pharmacy Benefit Manager* Specifically with respect to its PBM, Illinois intends to adopt a suite of utilization and care management programs that will promote appropriate prescribing patterns and utilization. This approach to chronic condition management will utilize face-

C.4.7	Utilization and care management
	to-face interaction with pharmacists and dedicated health coaches to improve outcomes and medication adherence and to build member self-care skills.

C.4.8	Processing and payment of claims
Requirement	Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.
Response	As with the existing high risk pools, Illinois will require that vendors have systems in place for processing and paying claims for health and prescription drug claims, including a point-of-sale claim system for prescription drugs. Illinois will require its administrator to maintain a system that provides online, real-time, highly automated claim adjudication. *Pharmacy Benefit Manager* Similarly, Illinois will require its PBM to maintain pharmacy administration that provides online, real-time eligibility verification and claim adjudication capabilities via an electronic point-of-sale technology.

C.4.9	Outreach and marketing
Requirement	Describe the qualified high risk pool's proposed efforts to conduct outreach and

C.4.9	Outreach and marketing
	marketing for the high risk pool program.
Response	Illinois proposes to use the following outreach methods: • Brochures will be developed and/or updated to include information about the THRP. • Information will be added to the Department of Insurance website. • Illinois proposes to notify prospective enrollees through advocacy organizations, other State agencies, and the Illinois Congressional delegation. Information packets containing eligibility requirements and application process and contact information will be distributed to the public through these allied offices. • Press events may be held to publicize the THRP. • Illinois also will coordinate radio interviews and other outreach efforts with other State agencies.

C.4.10	Anti-dumping provisions
Requirement	Describe the process the qualified high risk pool proposes to use to identify and report to HHS instances in which health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in compliance with A.4.10.
Response	Illinois' existing high risk pool statute has anti-dumping provisions that Illinois proposes to use for the THRP. For example, current Illinois provisions do not allow an applicant to reside in a public institution or allow applicants' premiums to be paid for or reimbursed by any government sponsored program or by any governmental agency or health care provider.

C.4.10	Anti-dumping provisions
	These provisions are intended to preclude government entities, employer groups and insurers from placing members or enrollees with pre-existing conditions into the existing high risk pools. In addition, Illinois will enforce the anti-dumping provisions as required by Section 1101(e) of the Affordable Care Act. Illinois proposes to build upon existing processes for reporting employer abuses to the U.S. Department of Labor. The enrollment application requires that each prospective enrollee detail information about the prospective enrollee's last insurance coverage. Prospective enrollees will need to disclose the last coverage date, by what insurer the coverage was provided, and why the coverage was terminated. Staff will also be trained to watch for irregularities and trends of abuse by insurers and employers. Staff will be trained to report abuses to the appropriate federal agency. The THRP web-page will provide consumers with information regarding who to contact if an employer unlawfully dropped that consumer from a group plan.

C.4.11	Waste, fraud, and abuse
Requirement	Describe the procedures that qualified high risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.
Response	In general, all State of Illinois employees must take and pass a stringent ethics training session upon employment and on an annual basis. The training establishes procedures for reporting waste, fraud and abuse. Staff will follow these standards and procedures. For purposes specific to the THRP requirements, staff will be trained to determine if a participant meets the qualification to participate in a specific pool. Illinois will expect any vendor engaged with the THRP to adhere to all relevant ethical standards.

C.4.12	Compliance risks
Requirement	Describe the system for routine monitoring and identification of compliance risks.
Response	Illinois will require its administrators to meet performance standards. These performance standards will include claim turnaround time, financial accuracy of claim payments, procedural accuracy of claim payments, telephone accessibility and response, complaint response turnaround, subrogation/subpoena and other legal cases, issuance of enrollment materials, and report production and transmittal. Adherence to the performance standards will be measured and reported each month based on a monthly audit by the plan administrator of its performance. See Appendix D: Performance Standards. In addition to these performance standards, Illinois will perform annual audits of the third-party prescription benefit management administrator, the plan administrator and our financial statements.

C.4.13	Coordination of benefits
Requirement	Describe the system the qualified high risk pool proposes to implement to coordinate benefits as described in A.4.13.
Response	The high risk pools in Illinois have an established system to coordinate payments with other payors. Illinois will utilize a similar system and employ the same approach with the THRP.

Table 1: Administrative Costs

Cost Category	Annual Administrative Costs				
	2010	2011	2012	2013	2014
Marketing and Outreach	$ 51,100	$ 135,500	$ 139,500	$ 143,700	$ 20,800
Member Materials	$ 21,800	$ 57,700	$ 59,400	$ 61,200	$ 10,500
Customer Service	$ 110,400	$ 292,400	$ 301,200	$ 310,200	$ 53,300
Provider Relations	$ 37,500	$ 99,400	$ 102,400	$ 105,500	$ 18,100
Information Technology	$ 201,300	$ 533,100	$ 549,100	$ 565,600	$ 97,100
Eligibility/Enrollment	$ 64,800	$ 171,500	$ 176,700	$ 182,000	$ 31,200
Premium Administration	$ 80,900	$ 214,100	$ 220,600	$ 227,200	$ 39,000
Claims Processing*	$ 106,800	$ 282,800	$ 291,300	$ 300,000	$ 51,500
Appeals/Reconsiderations	$ 8,600	$ 22,700	$ 23,400	$ 24,100	$ 4,100
Legal Services	$ 1,100	$ 3,000	$ 3,100	$ 3,200	$ 500
Accounting Services	$ 10,400	$ 27,600	$ 28,500	$ 29,300	$ 5,000
Actuarial Services	$ 17,600	$ 37,400	$ 38,500	$ 39,600	$ 6,800
Procurement	$ 6,000	$ 16,000	$ 16,400	$ 16,900	$ 1,300
Personnel Expenses	$ 273,200	$ 723,600	$ 745,300	$ 767,700	$ 66,300
Overhead**	$ 30,200	$ 80,000	$ 82,400	$ 84,900	$ 14,600
Other Administrative Costs***	$ 21,300	$ 56,500	$ 58,200	$ 59,900	$ 10,300
TOTAL	$ 1,043,000	$ 2,753,300	$ 2,836,000	$ 2,921,000	$ 430,400

* **Claims Processing** includes prescription drug point of sale claims.
** **Overhead** includes rent, data/telecommunications costs, postage, depreciation, travel, repair & maintenance, insurance, subscriptions & information services, training and other miscellaneous costs.

*** **Other Administrative Costs** includes coding, project development, operation support, formulary administration and development, sales administration and clinical administration for our pharmacy benefit manager and bank fees.

Illinois anticipates operating the THRP at or near the administrative expenses of its existing high risk pools (between 5-6%).

The administrative costs projected in Table 1 include all administrative costs that Illinois anticipates during each calendar year from 2010-2013.

ILLINOIS RESPONSE TO HHS TEMPORARY HIGH RISK POOL SOLICITATION

APPENDIX A:

Illinois CHIP Summary of Coverage

ILLINOIS

COMPREHENSIVE

HEALTH

INSURANCE

PLAN

Eligibility Requirements, Description of Benefit Plans and Summary of Coverage

Information contained herein is based on the Comprehensive Health Insurance Plan Act (215 ILCS 105/1 et seq), as most recently amended by Public Act, and is subject to change without notice. This is not a legal document. This Summary of Coverage replaces all earlier versions.

OB 2103 08-09

A State Program for Eligible Illinois Residents Who Qualify for Coverage Under the CHIP Act

INTRODUCTION

The Illinois General Assembly has created the Comprehensive Health Insurance Plan (CHIP). Section 7 of the CHIP Act provides access to health insurance coverage for certain Illinois residents who have been denied major medical coverage by private insurers because of their health. This portion of the program is known as the Section 7 or Traditional CHIP pool (referred to herein as Section 7). Section 15 of the CHIP Act provides access to health insurance coverage pursuant to the individual portability requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) and as a qualified plan for federally eligible individuals who qualify for the federal Health Coverage Tax Credit (HCTC) under either the Trade Adjustment Assistance (TAA) or the Pension Benefit Guarantee Corporation (PBGC). This portion of the program is known as the Section 15 or HIPAA pool (referred to herein as Section 15).

CHIP is a state program operated by a board of directors pursuant to the Comprehensive Health Insurance Plan Act (215 ILCS 105/1 et seq.). CHIP is NOT an insurance company. It is subject to its own enabling Act, and is neither an entitlement nor a welfare program. You must be eligible for this state program before you can enroll. Once enrolled, you must continue to meet all of the CHIP eligibility requirements. Failure to do so will result in your termination from the program as of the date required by CHIP or state law.

The Section 7 pool is funded in part by the premiums paid by its participants. The remainder of the cost of Section 7 is funded by appropriations from the General Revenue Funds of the State of Illinois. The Section 15 pool is also funded in part by premiums paid by its participants. The remainder of the cost of this Section 15 pool is funded by an assessment levied on all health insurers doing business in Illinois.

The eligibility criteria for CHIP are different from those for private health insurance, and the eligibility criteria for the Section 7 pool are different from those for the Section 15 pool.

This brochure briefly describes the eligibility requirements and application procedures for CHIP, and the various benefit plans offered by CHIP. It includes a Summary of Coverage which describes the benefits, limitations, exclusions, continuation, renewal and termination provisions. THIS BROCHURE IS NOT A LEGAL DOCUMENT. The actual provisions of any benefit plan booklet which may be issued to you will control. Whenever any information contained in this brochure is in conflict with the provisions of the CHIP Act, the statutory provisions shall control.

BENEFIT PLAN CHOICES

The benefit plan choices depend on how you qualify for CHIP. The following description is a brief overview of the major differences in each plan choice. Refer to the benefit plan descriptions below for more information about each of these choices.

Section 7 Pool: There are two plans available to eligible persons who qualify under the Section 7 Pool: the Medicare Plan, and the Traditional Plan. The Traditional Plan has both standard deductibles and High Deductible Health Plan (HDHP) deductibles available. The Section 7 Pool is available only to persons who have been denied major medical coverage by private insurers because of their health. All Section 7 Pool options are subject to a six-month preexisting conditions limitation.

The Medicare Plan is the only plan available to eligible persons who are enrolled in both Parts A and B of Medicare due to disability or end-stage renal disease since they are ineligible for all other CHIP benefit plans. The Medicare Plan does not provide coverage for prescription drugs (except in very limited circumstances). The Medicare Plan is not available or renewable beyond the date a person would have been eligible for Medicare due to age. Benefits under the Medicare Plan are always secondary to Medicare, and are reduced by any amounts payable under Medicare Parts A and B. This is referred to as a "carve-out" plan that is secondary to Medicare (Medicare will pay benefits first, and will be the "primary" coverage). The Medicare Plan has five deductible options to choose from: $500, $1,000, $1,500, $2,500 and $5,000.

The Traditional Plan is a Preferred Provider Organization (PPO) plan available only to eligible persons who qualify for coverage because they have been denied major medical coverage due to their health by private insurers and are not eligible for Medicare. To receive maximum benefits under this plan, a designated PPO provider must be used. The Traditional Plan has five standard deductible options to choose from: $500, $1,000, $1,500, $2,500 and $5,000.

The Traditional Plan also has deductible options available to persons who qualify for coverage under Section 7 and who are interested in purchasing a plan that qualifies as a High Deductible Health Plan (HDHP) that can be used in conjunction with a federally approved Health Savings Account (HSA). All covered services and supplies, including prescription drugs, are subject to a deductible which must be satisfied before the plan will pay any benefits. The Traditional Plan has three HDHP deductible options to choose from: $1,200, $2,000 and $5,200. These Traditional Plan HDHP deductible options are subject to change, based on the federal requirements for minimum and maximum deductibles for HDHP plans.

Section 15 Pool: There are two ways to qualify for coverage under the Section 15 pool. The first way is to be considered a federally eligible individual under HIPAA. The second way is to be registered with and approved by the IRS to claim the Health Coverage Tax Credit (HCTC) either as a recipient of benefits through Trade Adjustment Assistance (TAA) or as a person whose pension is provided through the Pension

Benefit Guarantee Corporation (PBGC). Preexisting conditions are covered under all Section 15 Pool options.

The HIPAA Plan is a Preferred Provider Organization (PPO) plan available only to federally eligible individuals who qualify for coverage because they have had prior creditable coverage and meet the other HIPAA requirements explained in more detail beginning on page 6. To receive maximum benefits under this plan, a designated PPO provider must be used. The HIPAA Plan has five deductible options to choose from: $500, $1,000, $1,500, $2,500 and $5,000.

The HIPAA-HCTC Plans are Preferred Provider Organization (PPO) plans available only to federally eligible individuals who qualify for the HCTC. There are two ways to qualify for the HIPAA-HCTC Plans: persons can qualify through the PBGC; or through the TAA. To receive maximum benefits under either of these plans, a designated PPO provider must be used. Each of these HIPAA-HCTC Plans has five deductible options to choose from: $500, $1,000, $1,500, $2,500 and $5,000.

Both the HIPAA and the HIPAA-HCTC Plans also have deductible options available, to persons who qualify for coverage under Section 15, and who are interested in purchasing a plan that qualifies as High Deductible Health Plan (HDHP) that can be used in conjunction with a federally approved Health Savings Account (HSA). All covered services and supplies, including prescription drugs, are subject to a deductible which must be satisfied before the plan will pay any benefits. The HIPAA-HDHP Plan, and the HIPAA-HCTC Plans each have three HDHP deductible options: $1,200, $2,000 and $5,200. The deductible options for each of these HIPAA Plans that qualify as HDHPs are subject to change, based on the federal requirements for minimum and maximum deductibles for HDHP plans.

ELIGIBILITY REQUIREMENTS FOR THE SECTION 7 POOL

The Section 7 pool consists of the Medicare Plan and the Traditional Plans, and, within its available resources, provides benefits for major medical expenses for as many resident eligible persons as possible who qualify under Section 7 of the CHIP Act. **A separate eligibility and enrollment form is required for each applicant. We may request other documentation to demonstrate that an applicant meets all of the statutory eligibility requirements in Section 7.**

The following requirements must be met in order to be eligible to enroll under Section 7 of the CHIP Act:

1. you must be a United States citizen or lawful permanent resident alien (proof required);
2. you must currently be a permanent resident of the State of Illinois and you must have been so for at least the past 180 days (proof of residency required). Once enrolled, you must remain a permanent Illinois resident; and
3. you must:
   a) have applied to an insurance company in the nine months prior to the time you apply for Section 7 and received a written rejection or refusal to issue,

due to health reasons, substantially similar individual health insurance coverage. A copy of this rejection notice, which must be on insurance company letterhead signed by a person with underwriting authority, must be submitted with your application for Section 7. A rejection or refusal by a group health plan or health insurer offering only stop loss, excess loss or reinsurance coverage with respect to the applicant is not acceptable; or

b) provide a copy of a refusal by an insurance company to issue or renew substantially similar individual health insurance except at a rate (for which you personally would be responsible for paying) that is more than you would pay for CHIP, in which case a notice of rejection from an insurance company is not required; or

c) provide a letter from your physician stating that you have any of the conditions listed below under Presumptive Medical Conditions, in which case a notice of rejection from an insurance company is not required.

You are not eligible for any of the PPO, or HDHP Plans if you are eligible for Medicare. If you are enrolled in both Parts A and B of Medicare due to disability or end-stage renal disease, however, you may still be eligible for coverage under the Medicare Plan. The coverage under this alternate Section 7 benefit plan would be secondary to your Medicare coverage. You must furnish a copy of your Medicare identification card and receive approval of an Eligibility and Enrollment Form. Once you become eligible for Medicare due to age, you will no longer be eligible for any CHIP plan and your Medicare Plan coverage will automatically end. If you are eligible or enrolled in only Part A or only Part B of Medicare, you are not eligible for and cannot enroll in the Medicare Plan. If either Part A or Part B of Medicare coverage is dropped or discontinued, you can no longer participate in the Medicare Plan. If you are eligible for Part B, but choose not to enroll in it for any reason, you are not eligible for and cannot enroll in the Medicare Plan.

Notwithstanding any of the above, Section 7 coverage is **not** available if:

1. you have or obtain other health insurance coverage that we determine to be substantially similar to or more comprehensive than Section 7 coverage or would be eligible for such coverage if you had elected to obtain it (unless the rate you yourself would be required to pay exceeds the applicable Section 7 Plan rate);
2. you receive or are approved to receive medical assistance (see the exception discussed below on Medical Assistance No Grant program (MANG);
3. you have voluntarily terminated coverage under CHIP within the past 12 months or if you have already received $2 million in benefits under CHIP ($1.5 million after August 28, 2010);
4. you are a resident of a public institution;
5. your premium is paid or reimbursed: (a) by a federal, state, county, municipal or any other unit of local government, or any agency thereof; (b) under any government-sponsored program; or (c) by any health care provider, including pharmaceutical companies, or any entity funded by or affiliated with such providers, except as an employee, or dependent of an employee, of a government agency or health care provider;

6. you have received benefits or funds from any settlement, judgment or award resulting from any accident, injury or other circumstance, regardless of the date of the accident or injury or any other circumstance, creating a legal liability for damages due that person by a third party so long as there continues to be benefits or assets remaining from those sources in an amount in excess of $300,000;
7. your coverage under any health care benefit program as defined in federal criminal law on health care offenses (18 U.S.C. 24), including any public or private plan or contract under which any medical benefit, item, or service is provided, was terminated as a result of any act or practice that constitutes fraud under state or federal law or as a result of an intentional misrepresentation of material fact (within 5 years prior to the date the application for CHIP coverage is received by the Board); or
8. you knowingly and willfully obtained or attempted to obtain, or fraudulently aided or attempted to aid any other person in obtaining, any coverage or benefits under the Plan to which you or that other person were not entitled.

Eligible persons enrolled in any Section 7 Plan may keep other substantially similar health insurance coverage solely for the purpose of having coverage for a preexisting condition, but **only** while satisfying the 6-month preexisting conditions limitations under CHIP.

PRESUMPTIVE MEDICAL CONDITIONS APPLICABLE TO THE SECTION 7 POOL

If you have any of the conditions listed below, you may apply for coverage under the Medicare Plan, or the Traditional Plans, without submitting a rejection notice from an insurance company. Instead, submit a letter from your physician describing your condition(s).

AIDS or AIDS Related Complex (ARC)
Angina Pectoris
Cerebrovascular Accident (Stroke)
Cirrhosis of the Liver
Coronary Occlusion
Friedreich's Ataxia
Hodgkin's Disease
Juvenile Diabetes
Leukemia
Metastatic Cancer
Muscular Atrophy or Dystrophy
Myotonia
Parkinson's Disease
Severe Traumatic Brain Injury
Silicosis Pneumoconiosis (Black Lung)
Wilson's Disease
Arteriosclerosis Obliterans
Chemical Dependency
Coronary Insufficiency
Cystic Fibrosis
Hemophilia (Classical)
Huntington's Chorea
Kidney Failure Requiring Dialysis
Lupus Erythematosus Disseminate
Multiple or Disseminated Sclerosis
Myasthenia Gravis
Paraplegia or Quadriplegia
Poliomyelitis
Polycystic Kidney
Sickle Cell Anemia
Syringomyelia

ELIGIBILITY REQUIREMENTS FOR SECTION 15 POOL:

The Section 15 pool consists of the HIPAA Plan and the HIPAA-HCTC Plans, and all have HDHP deductible options available.

All of these Plan options provide benefits for certain major medical expenses without imposing any preexisting condition exclusions for Illinois residents who are federally eligible individuals and qualify under Section 15 of the CHIP Act.

You need not have been refused health insurance coverage by any insurance issuer or plan nor have any special medical condition in order to be a federally eligible individual. Also, under state and federal law, there cannot be a waiting list for coverage under Section 15.

If you qualify under Section 15, and are enrolled in Parts A and B of Medicare due to disability or end-stage renal disease, you can enroll only in the HIPAA Plan. Once you have been enrolled for the first six months, the HIPAA Plan will terminate and you will then be moved to the Medicare Plan, with the Medicare Plan premium rates. This Medicare Plan has very limited prescription drug coverage. (See the Medicare Plan description for additional information.)

No preexisting condition limitation applies to this HIPAA Plan coverage, which is always secondary to Medicare and requires the payment of HIPAA Plan premiums. Instead of enrolling in the HIPAA Plan, you can enroll in the Section 7 Medicare Plan. However, a six-month preexisting condition limitation and the Medicare Plan premiums would apply to the Medicare Plan.

WHO ARE FEDERALLY ELIGIBLE INDIVIDUALS?

To qualify as a federally eligible individual under the HIPAA Plan, including the HIPAA Plan with an HDHP deductible, you must:

1. be a United States citizen or lawful permanent resident alien (proof required);
2. be a permanent resident of the State of Illinois (proof of residency required);
3. have at least 18 months of prior creditable coverage;
4. have no more than a 90-day break between periods of creditable coverage;
5. have had your most recent creditable coverage under group health insurance coverage provided by a health insurance issuer, a group health plan, a governmental plan or a church plan;
6. have elected and exhausted COBRA or other continuation coverage, if offered;
7. have completed, signed and submitted the proper application for coverage that is received by the CHIP Board Office within 90 days of the date your most recent health insurance coverage ended;
8. not receive, be approved to receive or be eligible for coverage under a group health plan, Part A or Part B of Medicare due to age or Medicaid/medical assistance;
9. not have any other health insurance coverage;

10. not have had your most recent coverage terminated due to nonpayment of premium or fraud;

Notwithstanding any of the above, the HIPAA Plan, including the HIPAA Plan with an HDHP deductible, is **not** available if you:

1. have or would be eligible for any coverage under a group health plan if you elected to obtain it;
2. have or obtain any other health insurance coverage, including an individual conversion policy;
3. have met the lifetime maximum in benefits under the CHIP Act.

To qualify as a federally eligible individual under any of the HIPAA-HCTC Plans, you must:

1. register with and be approved for the HCTC program as TAA certified or as a PBGC pensioner;
2. be a United States citizen or lawful permanent resident alien (proof required);
3. be a permanent resident of the State of Illinois (proof of residency required);
4. have at least a total of three months of prior creditable coverage;
5. have no more than a 63-day break between periods of creditable coverage;
6. have completed, signed and submitted the proper application for coverage that is received by the CHIP Board Office within 63 days of the date your last creditable coverage ended;
7. not be enrolled in a health plan maintained by the current or former employer of the HCTC eligible individual or spouse if such employer pays at least 50% of the cost of coverage;
8. not be entitled to Medicare Part A or enrolled in Medicare Part B;
9. not be enrolled in the Federal Employees Health Benefit Program (FEHBP), Medicaid/medical assistance or State Children's Health Insurance Program (SCHIP);
10. not be entitled to health coverage through the U. S. Military health system (TRICARE/CHAMPUS).

WHAT IS CREDITABLE COVERAGE?

Creditable Coverage means, with respect to a federally eligible individual, coverage of the individual under any of the following:

1. A group health plan;
2. Health insurance coverage (including group health insurance coverage);
3. Medicare;
4. Medical assistance or Medicaid;

5. TRICARE/CHAMPUS, or other health benefit plans for the uniformed services of the United States;
6. A medical care program of the Indian Health Service or of tribal organizations;
7. A state health benefits risk pool (such as CHIP);
8. The Federal Employees Health Benefits Program (FEHBP);
9. A public health plan established by a state, county, or other political subdivision of a state that provides health insurance coverage; or
10. A health benefit plan under the Peace Corps Act.

HOW DO I APPLY FOR SECTION 15 COVERAGE?

To apply for coverage under one of the Section 15 plans, please submit the following documents:

1. A completed and signed Eligibility and Enrollment Form.
2. The certificate of creditable coverage provided by your prior plan or insurer (or other acceptable written documentation that verifies your coverage) for each period of creditable coverage you have had without a substantial break in coverage. The HIPAA Plan, including the HIPAA Plan with HDHP deductible options, requires at least 18 months of prior creditable coverage without a substantial break in coverage. The HIPAA-HCTC Plans, including the HIPAA-HCTC Plans with HDHP deductible options, each require at least 3 months of prior creditable coverage without a substantial break in coverage.
3. The COBRA or other termination letter(s) you have received from your previous employer or prior group plan advising you that any continuation rights you were eligible for have been (or soon will be) fully exhausted and that your coverage under this group has been (or soon will be) terminated. You will need to include a canceled check or other evidence that establishes that you have made the final premium payment to continue your coverage through the end of the continuation period for which you are eligible.
4. Depending upon your specific circumstances, we may also need to obtain additional documentation to establish your eligibility for this Section 15 coverage.

Submit your application 90 days prior to the expiration of your COBRA or state continuation to allow time to process your application before your other coverage ends. **Your CHIP effective date cannot be backdated. Also, you should understand that if you exercise any rights to convert from a group to an individual policy, you will then be ineligible for the Section 15 Pool.**

For the HIPAA Plan, including the HIPAA Plan with an HDHP deductible, your application and other supporting documentation must be received by the Board office no later than 90 days after the termination of any prior group insurance coverage including COBRA or any other continuation coverage that you might receive. For the HIPAA-HCTC Plans, including the HIPAA-HCTC Plans with the HDHP deductible option, your application and other supporting documentation must be received by the Board office no later than 63 days after the termination of any prior group insurance coverage including COBRA or any other continuation coverage that you might receive. If you miss the

important deadline for submitting your application, or do not meet any of the other requirements to be a "federally eligible individual," you may still be eligible for coverage under Section 7 (with a six-month limitation or waiting period on benefits relating to preexisting conditions) if you complete, sign and submit an Eligibility and Enrollment Form and such documentation as required to demonstrate that you meet all of the eligibility requirements in Section 7.

WHAT RESIDENCY RULES APPLY?

To qualify as an eligible person under Section 7 (the Medicare Plan, or the Traditional Plans), you must be a permanent resident of the State of Illinois who has been legally domiciled in Illinois for a period of at least 180 days. To qualify for any of the Section 15 Plans (the HIPAA Plans, and any of the HIPAA-HCTC Plans) as a federally eligible individual, you must be a permanent Illinois resident who is legally domiciled in Illinois. To maintain residency in the State of Illinois for purposes of remaining eligible for and participating in CHIP, you must continue to reside in a place of permanent habitation which remains your principal residence within the State of Illinois, and continue to remain present in Illinois for the foreseeable future except when absent for temporary or transitory purposes. The use of a relative's or friend's address to maintain an Illinois mailing address is not sufficient to meet this requirement, and is not enough to preserve your eligibility for CHIP and any coverage you might later receive under CHIP, unless you continue to physically reside there on a permanent full-time basis. We may periodically require verification of residency and may require any additional information or documentation, or statements under oath, from you when necessary to determine your residency for the entire term of your CHIP coverage. A child or legally incompetent adult is legally domiciled in Illinois if the child or legally incompetent adult lives in Illinois and his or her custodial parent(s) or legal guardian-of-the-person is legally domiciled in Illinois.

WHAT ARE THE SPECIAL RULES REGARDING MEDICAID AND THE MEDICAID/MEDICAL ASSISTANCE PROGRAM?

If you receive or are approved to receive medical assistance from any state's Medicaid/medical assistance program, you will immediately lose your eligibility for any CHIP coverage. Any CHIP coverage which may have been issued to you will end as of the date any such Medicaid/medical assistance is available to you. However, if you are a participant in the Medical Assistance program with a "spenddown" requirement, you may continue to receive medical assistance under that specific program only while satisfying the preexisting conditions limitation under the Medicare Plan, or the Traditional Plans (Section 7). In that event, your premium payment can be allocable to your medical assistance spenddown during this six-month preexisting conditions limitation period; but you will not be eligible for any benefits under CHIP for expenses incurred while you remain eligible for or approved to receive any medical assistance. Once the preexisting conditions limitation period has elapsed, your eligibility for any medical assistance must have terminated or your CHIP coverage will end as of the expiration of this preexisting conditions limitation period. At no time can any person be eligible to receive benefits under CHIP and medical assistance from the Illinois Department of Healthcare and Family Services or any other state's Public Aid at the same time.

ARE OTHER FAMILY MEMBERS ELIGIBILE?

Other resident members of the same household are eligible for coverage if each member meets all of the eligibility requirements. Family members who are eligible under this provision include spouses and/or unmarried children whom you claim as a dependent in accordance with Internal Revenue Service requirements as long as they remain Illinois residents; continue to permanently reside in the same household as the eligible person; and are named in an application for coverage. The oldest adult family member who qualifies for and is enrolled in CHIP will be charged the applicable premium rate. Additional family members who qualify for and are enrolled in the same CHIP benefit plan, and have the same deductible, will pay a special family rate of 80% of the otherwise applicable premium rate for each additional family member(s).

HOW DO I APPLY OR OBTAIN ADDITIONAL INFORMATION?

Eligible Illinois residents can apply for any of the CHIP benefit plans that are available under one of the State's two CHIP pools directly through the Board office, or through any agent or producer licensed to sell health insurance in Illinois. Parents or legal guardians of the person may apply on behalf of resident dependents or legally incompetent individuals. Guardianship or power of attorney papers are required. Separate applications are required for each applicant. Additional information about CHIP coverage, rates and how to apply can be obtained from your insurance agent, or by calling, writing, or visiting our website:

Office of the Board of Directors
Illinois Comprehensive Health Insurance Plan
320 West Washington Street, Suite 700
Springfield, Illinois 62701-1150
(217) 558-6202 *(Voice)*
(800) 545-2455 *(TTY)*
(217) 558-4831 *(Fax)*
1-866-851-2751 *(toll-free in Illinois)*
www.chip.state.il.us

GENERAL INFORMATION ABOUT THE APPLICATION PROCESS

Please carefully read the earlier sections on Eligibility Requirements. Make sure that you include all of the required notices, including both residency and medical eligibility or certificate of creditable coverage, with your completed Eligibility and Enrollment Form. Be sure to carefully read your entire application, and make certain you fully comply with all of the requirements stated in the Eligibility and Enrollment Form. Failure to comply with all of these requirements will delay the processing of your application. Any partially completed application which is received by CHIP will be returned.

You should not drop any existing coverage or in any way assume that you have or will soon receive any type of coverage under CHIP. You will not be covered under either CHIP Pool until your application can be finally approved and a benefit plan booklet has been issued to you, which will be after you have been notified of an opportunity for enrollment, and your full initial premium, application update, if applicable, and other necessary documentation have been received and approved.

Once you have submitted a completed Eligibility and Enrollment Form, you will be notified whether your application has been conditionally approved, pended or denied. If we need additional information in order to determine your eligibility, or must place your name on a waiting list, we will notify you. If your application is denied, the reason for denial will be explained to you.

Each application is subject to final approval by the Board office. The receipt and cashing of premium checks by the Administrator or CHIP Board shall not constitute acceptance of the application or be binding in any way, nor shall such receipt or cashing of checks establish or create any temporary or interim coverage of any sort.

IMPORTANT NOTICE OF LIMITATION ON ENROLLMENT IN THE MEDICARE PLAN, THE TRADITIONAL PLAN OR THE TRADITIONAL HDHP PLAN (THE CHIP SECTION 7 POOL).

Based on the amount of state money that is available to subsidize the Section 7 Pool, the Board of Directors of CHIP is required to limit or close enrollment in the Medicare Plan, the Traditional Plan and the Traditional HDHP Plan in order to ensure that sufficient resources exist to meet obligations to existing participants. Thus, it is possible that enrollment in Traditional CHIP at the time you apply may be closed or have reached that limit.

In that event, the Board will continue to accept and process applications for coverage under the Section 7 pool. Applicants who appear to qualify except for the enrollment limitation will then be placed on a waiting list in the order in which their application is found to be complete. As additional enrollment opportunities become available, applicants will then be contacted in the order in which their names appear on the waiting list; therefore, anyone seeking coverage under the Medicare Plan, the Traditional Plan or the Traditional HDHP Plan (Section 7) should apply as soon as possible. Call our toll-free number at 1-866-851-2751 (toll free voice – Illinois only) or 1-800-545-2455 (TTY), and we can advise you if there is currently a waiting list.

There is no limitation on enrollment in Section 15 Pool (including the HCTC), and there cannot be a waiting list for the Section 15 Pool under state and federal law.

GRIEVANCE PROCEDURE

If your application is rejected by CHIP, you will receive written notice of the denial, together with the specific reason. You have 60 days from the date you receive a written denial in which to send a written complaint to the CHIP Board office. A copy of the entire three-step CHIP Grievance Procedures can be obtained from the CHIP Board office.

SUMMARY OF COVERAGE

This Summary of Coverage provides a brief description of the important features of the benefit plans that are available under CHIP. This Summary of Coverage replaces all earlier versions. This is not a legal document. The actual provisions of any benefit plan booklet which may be issued to you will control. The benefit plan booklet itself sets forth in detail the rights and obligations of both you and the Illinois Comprehensive Health Insurance Plan. Certain benefits and covered services may be subject to conditions, limitations or exclusions. It is, therefore, important that, if you enroll in CHIP, YOU CAREFULLY REVIEW AND FAMILIARIZE YOURSELF WITH THE BENEFIT PLAN BOOKLET WHICH YOU WILL RECEIVE.

THE PLAN ADMINISTRATOR

CHIP uses two different Administrators:

1. The Administrator for membership and all benefits except prescription drugs is:

   Blue Cross Blue Shield of Illinois (Blue Cross/Blue Shield)
   Toll-free Number 800-367-6410 (General Information & Claims)
   Hearing Impaired 800-545-2455 (TTY)
   800-232-6179 (Pre-Admission Review and Prior Approval)

2. The Administrator for prescription drug benefits only (drugs purchased at a retail or mail order pharmacy) is:

   Walgreens Health Initiatives (WHI)
   Toll-free Number 800-207-2568 (Member Services) - 888-411-0767 (TTY)
   888-782-8443 (Specialty Pharmacy) -866-830-4366 (TTY)
   888-265-1807 (Mail Order)

COMMON CHARACTERISTICS OF THE PLANS:

Regardless of the Plan in which you enroll, the following provisions and requirements apply:

LIFETIME MAXIMUM

The maximum amount CHIP will pay in medical and drug benefits for you in your lifetime is $2 million for all sicknesses and injuries combined. (The $2 million lifetime maximum will be reduced to $1.5 million on August 29, 2010.)

RENEWAL AGREEMENT AND/OR REENTERING THE PLAN AFTER TERMINATION

Provided you remain eligible, your CHIP coverage can be renewed each time you properly pay the required premium by the due date or during the 31-day grace period that follows. Premiums are based on your age, sex, geographical location, your deductible, any other option you have chosen for which you qualify, and the Plan in which you are eligible and enrolled. If any of these factors change, your premium will

also change. **If we do not receive your premium by its due date, any coverage which may be issued to you will terminate as of the last day for which your CHIP coverage previously had been paid.**

You alone are responsible for assuring that we receive your premium by its renewal date. If you elect to have an eligible third party make your premium payments, you assume full responsibility for the failure of that party to remit in a timely manner or for any other occurrence that results in your premium not being received by the renewal date.

If your coverage terminates for non-payment of premium, you will have no right of reinstatement. If for any reason you voluntarily terminate your CHIP coverage, you may later reapply for coverage under CHIP. If we determine you are then otherwise eligible for CHIP coverage, your new CHIP coverage cannot take effect until at least 12 months have elapsed since you voluntarily terminated this CHIP coverage, unless you can qualify as a federally eligible individual under Section 15 of the CHIP Act. **Nonpayment of premium is considered a voluntary termination of your CHIP coverage.**

CONTINUATION OF COVERAGE

Upon the death or divorce of a qualifying participant for CHIP coverage, every other person then covered as a dependent under that person's CHIP coverage or in the case of a covered dependent reaching the limiting age, each such person may within 60 days of that qualifying event elect to continue under their own separate CHIP coverage provided that person is eligible and submits appropriate documentation as required within the time allowed. The effective date of any new coverage shall be the date of the termination of the previous coverage.

Continuation is subject to the Renewal Agreement provisions of the CHIP coverage and payment of the required premium.

MODE OF PAYMENT

You may elect to pay your CHIP premium semiannually, quarterly, or monthly. The initial premium payment must be tendered by certified check, cashier's check or money order. Any account that you use to have us draft your monthly premium must be through a financial institution within the State of Illinois, as we will not draft out-of-state accounts. Check the enclosed premium rate tables carefully to choose the mode of payment that best suits your needs.

The monthly payment mode for the Medicare Plan, the Traditional Plans, and the HIPAA Plans, is through an automatic draft system. If you elect to pay your premiums monthly, we require that you pay the first two months of premiums when you enroll. This will give us time to set up the process that allows your premiums to be automatically deducted from your account. A monthly invoice option is available only to HCTC participants (the HIPAA-HCTC Plans) since these premium payments are coordinated with the HCTC.

If your CHIP coverage terminates for non-payment of premium, you will have no right of reinstatement.

You are responsible for paying the premium when due, even if, for any reason, you do not receive a premium due notice. You should, therefore, keep track of when your premium is due, and mail your premium sufficiently in advance of when it is due. You also assume full responsibility for any occurrence that results in your premium not being received by us and honored by the renewal date, including the loss or delay in delivery of your premium payment. A monthly bank draft mode of payment is available for the Medicare Plan, the Traditional Plan, the Traditional HDHP Plan, and the HIPAA Plan, including the HIPAA Plan with HDHP deductible options, which electronically debits a bank account of your choice each month, and avoids your having to remit your renewal payments by mail; however, you are still responsible for paying the premium when it is due. No agent or other office is authorized by us to accept payment of premiums on behalf of CHIP.

PREMIUMS

Your premium is based on your age, sex, geographical location, your deductible, the benefit plan and any other options you have chosen and/or are eligible for. Your premiums will change when you reach a new age category as set forth in our premium rate tables. Your premium will change if your place of residence changes from one geographical rating area to another within the State of Illinois. Your premium will also change if any of the other factors used to determine your premium change. The new premium will go into effect on the renewal date that coincides with or next follows the change in age, residency or any of the other factors. These changes will be reflected automatically in any premium due notices you receive. Premiums which were previously paid based on incorrect information will have to be adjusted as of the date the change in premium would otherwise have occurred.

Your premium also will change when there is a need for new premium rate tables. We can apply revised rates only if we do the same thing for all CHIP participants with the same benefit plan provisions, benefits, and schedule of premium rates, who have the same rating factors or classifications. Premium changes will be made no sooner than the renewal date that coincides with or next follows the effective date of the new schedule of rates. We will give you at least 30 days notice prior to the effective date of this type of change. Notice will be mailed to the last address we have for mailing information to you.

A copy of the current Premium Rate Tables is available as an insert to this brochure. We expect premiums to change every six months. If you need a copy of the current rate tables, or if the date on your copy is more than six months old, please call (217) 782-6333 or 1-800-962-8384 (toll-free in Illinois). Rate tables and a premium calculator are available on our website at www.chip.state.il.us.

OTHER SOURCES PRIMARY/NONDUPLICATION OF BENEFITS

CHIP is the last payor of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under CHIP shall be reduced by all

amounts paid or payable or reimbursed directly by or under:

1. the laws of the United States, or the State of Illinois, including Medicare or any other government program;
2. military service-connected disability payments;
3. medical services provided for current or retired members of the Armed Forces and their dependents, or employees of the Armed Forces of the Unites States;
4. hospital or medical services paid or payable under or provided pursuant to any state or federal law or program;
5. a workers' compensation or occupational disease law;
6. automobile medical payment or liability insurance, whether provided on the basis of Fault or No Fault coverage;
7. any other coverage which provides insurance, reimbursement or benefits for hospital, surgical or other medical expenses, whether insured or otherwise; or
8. any third-party liability, settlement, judgment or award, regardless of (i) the date of the settlement, judgment or award; (ii) the form of such settlement, judgment or award; and (iii) to whom or the manner in which such settlement, judgment or award is payable.

CHIP reserves the right of recovery for any payments we made for a loss that is payable by other insurance coverage, health plans, other government programs or any other coverage or source of third party payment. We may also recover payments that we made for losses not covered under your CHIP coverage or in excess of the benefits provided thereunder. Benefits due from CHIP may be reduced or refused as an offset against any amount otherwise recoverable.

RIGHT TO RECOVER

CHIP reserves the right to recover, from any amounts you receive or may receive from a third party that caused your injury or sickness, any payments that CHIP has made for expenses you incurred on account of that injury or sickness. We can make such recovery by receiving reimbursement from you or on your behalf, regardless of the date of the injury or sickness or the date of such settlement, judgment or award.

DESCRIPTION OF BENEFITS BY TYPE OF PLAN:

Depending on the Plan in which you enroll, the following provisions and requirements apply. Refer to the Description of Coverage section of the brochure for additional information.

PREFERRED PROVIDER (PPO) PLANS

The Traditional Plans, the HIPAA Plans, and the HIPAA-HCTC Plans are all PREFERRED PROVIDER (PPO) PLANS.

Persons enrolling in any of the PPO plans listed above can obtain hospital and medical services from any provider of their choosing. Reimbursement rates will be less,

however, if hospital or medical services are obtained at a non-PPO provider and are subject to separate out-of-network co-payment and expense limitation requirements. These are in addition to the calendar year deductible and out-of-pocket expense amount. In addition, if a participant is confined in a non-PPO hospital, there will be a separate $300 deductible for each such admission. Once all appropriate deductibles are met, the reimbursement rates for any PPO Plan will be:

PPO Provider:	80% of covered charges
Non-PPO Provider:	60% of covered charges

In order to obtain maximum benefits for hospital or medical services, any person who enrolls in any of the PPO Plans will need to use one of the participating providers in the Administrator's PPO network. PPO providers are conveniently located throughout Illinois.

Participants in any of the PPO Plans will receive a CHIP-PPO identification card that contains a Blue Cross Blue Shield logo. This will identify them as a member of the Administrator's PPO program, and allow them to receive in-network benefits while traveling anywhere in the United States subject to a 45 day per calendar year limit on services provided by out-of-state hospitals in most cases.

Call 1-800-810-2583 or visit the Plan Administrator's website at www.bcbsil.com to verify which providers are participating in its PPO network.

The Medicare Plan is not a PPO Plan, since Medicare is always primary.

PRESCRIPTION DRUG CARD BENEFITS

Coverage for prescription drugs obtained through a retail or mail-order pharmacy is provided through a drug card program for persons enrolled in the Traditional Plans, the HIPAA Plans, and the HIPAA-HCTC Plans. The ID card that is issued to participants eligible for this prescription drug card program provides information to the pharmacy for submitting claims at the time the prescription is obtained. Call or visit the Prescription Drug Administrator website at www.mywhi.com to find a participating pharmacy.

There are no prescription drug card benefits available under the Medicare Plan.

ANNUAL ELECTION PERIOD

If you are enrolled in any of the PPO Plans, you have the right to change to or from an HDHP plan annually, as of January 1st of any calendar year, provided you remain eligible for and enrolled in any of these PPO Plans. You can change your CHIP coverage from an HDHP to a non-HDHP or from a non-HDHP to an HDHP option. You must do so during the annual election period, which occurs at the end of every calendar year. The change will become effective on January 1 of the next calendar year after we have received and approved your properly completed election form. If an election form is not received by December 31st, it will not be accepted.

PPO DEDUCTIBLES

All of the PPO plans contain a calendar year deductible. This deductible must be satisfied before the plan begins to pay any benefits. In addition to the deductible described below, there is also a separate $300 deductible that applies for each admission to a non-PPO hospital.

All non-HDHP PPO Plans (the Traditional Plan, the HIPAA Plan, and the HIPAA-HCTC Plans without HDHP deductible options) have a choice of five deductible options. Depending on the coverage selected, the annual deductible amount will be $500, $1,000, $1,500, $2,500 or $5000. A family annual deductible of two times the individual annual deductible applies under these plans if three or more members of the same family are covered under the same CHIP plan and deductible option. A reduction in premium also is available if more than one family member enrolls (see “Are Other Family Members Eligible” on page 10).

All HDHP options (the Traditional HDHP Plan, the HIPAA-HDHP Plan, and the HIPAA-HCTC Plans with HDHP deductibles) have a choice of the following deductibles: $1,200, $2,000 and $5,200. These PPO plans qualify as High Deductible Health Plans (HDHP) and can be used with a Health Savings Account. A family annual deductible is not available for any of the HDHP plans. A reduction in premium, however, is available if more than one family member enrolls (see “Are Other Family Members Eligible” on page 10).

Once you enroll, the deductible cannot be decreased; however, it may be increased on any January 1st following the date your written request to increase it is received. Persons enrolled in the $5,200 HDHP deductible can enroll in the $5,000 deductible if they are changing from an HDHP to a non-HDHP option during their annual election period. This is the only time that a lower deductible can be chosen. (See annual election process described above.)

OUT-OF-POCKET EXPENSE AMOUNT

The Out-of-Pocket Expense Amount is the total of both the deductible and the coinsurance for which you are responsible and must pay out of your own pocket each calendar year at the PPO payment level before we will begin to pay at a rate of 100% of your covered expenses. Charges in excess of the usual and customary fee, or in excess of the eligible charge or maximum allowance, non-covered charges, and charges for services which have separate benefit limits cannot be applied toward the out-of-pocket expense amount. Any penalties or co-payments resulting from failure to comply with cost containment, outpatient treatment of mental illness or substance abuse, organ transplant or PPO provisions also cannot be applied toward the out-of-pocket expense amount. Note that there are separate maximum out-of-pockets per calendar year that apply to the Traditional Plan, the HIPAA Plan, and the HIPAA-HCTC Plans that do not have HDHP options. One out-of-pocket maximum is for prescription drugs obtained through a retail or mail-order pharmacy, while another out-of-pocket maximum applies to major medical. The Traditional HDHP Plan and the HIPAA-HDHP Plans (including the HIPAA-HCTC plans with HDHP deductible options) have a

combined out-of-pocket per calendar year that applies to both the major medical and prescription drug benefits.

The out-of-pocket expense amount is $1,500 coinsurance plus the applicable deductible per calendar year for all plans with a $500, $1,000, $1,200, $1,500, $2,500 and $5,000 deductible. The out-of-pocket expense amount for the $2,000 deductible plans is $4,500 (the $2,000 deductible plus $2,500 coinsurance) per calendar year. The out-of-pocket expense amount for the $5,200 deductible plan is $5,200 per calendar year (100% coinsurance after the $5,200 deductible is met.)

OUT-OF-NETWORK EXPENSE LIMIT

The Out-of-Network Expense Limit is in addition to the Out-of-Pocket Expense Amount and the deductible that applies to each Non-PPO hospital admission. It represents the total amount of additional covered expenses you must pay out of your own pocket each calendar year for any covered expenses you receive from a Non-PPO provider before we will begin to pay at a rate of 100% of your covered expenses. Charges in excess of the usual and customary fee, or in excess of the eligible charge or maximum allowance, non-covered charges, and charges for services which have separate benefit limits also cannot be applied toward the out-of-network expense limit. Any penalties or co-payments resulting from failure to comply with cost containment, outpatient treatment of mental illness or substance abuse, or organ transplant provisions cannot be applied toward your out-of-network expense limit.

PPO PLANS WITH THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP) DEDUCTIBLE OPTIONS

The Traditional HDHP Plan, the HIPAA-HDHP Plan, and the HIPAA-HCTC Plans with the HDHP option qualify as high deductible health plans that can be used in conjunction with a federally approved Health Savings Account (HSA). All HDHPs are PPO plans. These plans cost less than the other PPO options with similar deductibles because the participant assumes a greater share of the cost of their health care expenses initially. An important difference between the HDHP plans and the other PPO plans is that the HDHP plans have no first dollar benefits (e.g., these plans will not pay for prescription drugs, second surgical opinions or hospital pre-admission testing until the deductible has been met). **The participant must meet the HDHP deductible before any benefits will be paid, including prescription drugs.**

HDHPs qualify for use with HSAs. An HSA is a tax-advantaged, individually owned savings account that can be used to cover a wide range of qualified medical expenses. That includes your annual deductible and, if applicable, any out-of-pocket cost-sharing for covered services. HSAs have tax and legal ramifications. The information in this brochure is for informational purposes only and is not intended as tax or legal advice. Consult a tax and/or legal professional for advice regarding HSAs.

The following is a listing of the differences between HDHPs and the other PPO Plans:

1. HDHP Plans do not have a family maximum deductible or a family maximum out-of-pocket.
2. All covered services and supplies, including prescription drugs, pre-admission testing, and second surgical opinions are subject to a deductible which must be satisfied before any of the HDHP plans will pay any benefits.
3. All HDHP plans have one out-of-pocket expense amount that applies to all benefits, whether major medical or prescription drugs. The out-of-network expense limit applicable to non-PPO services still applies.

MEDICARE CARVE-OUT PLAN (THE MEDICARE PLAN)

The Medicare Plan is the only plan available to persons enrolled in both Parts A and B of Medicare (except for the HIPAA Plan, which is only available on a limited, short-term basis). This plan is secondary to Medicare and provides limited benefits after the deductible and out-of-pocket expenses have been met.

Depending on the coverage selected, the annual deductible amount will be $500, $1,000, $1,500, $2,500 or $5,000. A family annual deductible of two times the individual annual deductible is available if three or more members of the same family are covered under the same CHIP plan and deductible option. A reduction in premium is available if more than one family member enrolls (see “Are Other Family Members Eligible” on page 10). Once you enroll, the deductible cannot be decreased; however, it may be increased on any January 1st following the date your written request to increase it is received.

There are no prescription drug benefits available under the Medicare Plan for the purchase of prescription drugs obtained through a retail or mail-order pharmacy; however, in certain limited instances Medicare Part B may provide prescription drug coverage. In these instances, such prescription drugs will be considered allowable under the Medicare Plan.

COINSURANCE

For a covered sickness or injury, once the deductible has been satisfied in any calendar year, all plans will pay a percentage of the usual and customary fee for covered services and supplies. If you enroll in the Medicare Plan, the covered percentage will be 80%. The other 20% (which you pay) is called coinsurance. If you enroll in any of the PPO Plans (the Traditional Plans, the HIPAA Plans, or the HIPAA-HCTC Plans), they also will pay 80% of covered charges, unless you use a provider which is not participating in our Administrator’s PPO network. In that case, these Plans will pay only 60% and you will be responsible for the other 40%.

Plan	Covered Percentage
The Medicare Plan	80% (Medicare is primary)
All Other Plans (the PPO Plans)	80%; 60% if non-PPO providers are used

These benefits are payable for covered expenses incurred for treatment or diagnosis of sickness or injury after CHIP coverage becomes effective. Coverage under the Section 7 Pool (the Medicare Plan, and the Traditional Plans) is subject to a six-month preexisting conditions limitation (see below).

PREEXISTING CONDITIONS LIMITATION

CHIP will not cover any charges or expenses incurred during the first six months after the effective date of any CHIP coverage available under the Section 7 Pool (the Medicare Plan, and the Traditional Plans) relating to any preexisting condition(s). Until this preexisting condition limitation has ended, no benefits will be provided under any such CHIP coverage for any expenses relating to any preexisting conditions.

After such six-month period, payment of benefits will be in accordance with the provisions of your CHIP coverage.

This preexisting conditions limitation does not apply to pregnancy. (See the Maternity Benefits and Exclusions – What is Not Covered by CHIP sections beginning on page 33 in this Summary of Coverage for more information.)

This preexisting conditions limitation also does not apply to any newborn, new legal ward or newly adopted child of any qualified participant who is currently covered by CHIP for whom a separate application for CHIP coverage is made and approved, and the additional required premium is paid for each child within 31 days after the newborn's birth or the new legal ward's or newly adopted child's placement.

This preexisting conditions limitation does not apply to covered persons who qualify under Section 15 of the CHIP Act and are enrolled as federally eligible individuals under the HIPAA Plans, or the HIPAA-HCTC Plans. This limitation also does not apply to any covered person who qualifies under Section 7 who has satisfied a similar preexisting condition exclusion under a prior individual policy that was involuntarily terminated because of the insolvency of the issuer of that policy, and who has applied for the Traditional Plans within 90 days following the involuntary termination of that individual health insurance policy.

DESCRIPTION OF COVERAGE:

This section describes benefits, limitations, exclusions and termination of coverage requirements of all Plans.

COVERED SERVICES, DRUGS AND SUPPLIES

The following is a brief description of the benefits provided by CHIP for covered services, drugs and supplies. These benefits are subject to all of the terms, conditions,

limitations and exclusions as set forth in more detail in any benefit plan booklet which may be issued to you. The actual provisions of any such specific CHIP benefit plan booklet shall control.

1. **Hospital Services**. Room and board at the semi-private room rate and miscellaneous hospital services, drugs and supplies which are furnished to you as an inpatient except that a limitation of 45 days per calendar year applies to all confinement in hospitals located more than 75 miles outside the State of Illinois. When confined in a private room, charges in excess of the semi-private room charge of the hospital are not covered unless prescribed as medically necessary by a physician. Hospital medical services, drugs and supplies which are furnished to you on an outpatient basis are also covered. Hospital services for mental illness or substance abuse are limited as provided under item No. 17 below. Organ or tissue transplants are limited as provided under item No. 18 below. Daily room and board and other hospital services, drugs and supplies which are furnished by a non-PPO hospital are payable at the non-PPO hospital level, and are subject to separate out-of-network coinsurance and expense limitation requirements. In addition, a separate $300 deductible applies for each admission to a non-PPO hospital. **Preadmission review is required for all inpatient admissions.**

2. **Professional medical services**. Professional services, including surgery, anesthesia, and diagnostic services, for the diagnosis or treatment of injuries or sicknesses rendered by a professional provider. Professional services also include reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Children under the age of 16 are covered for physical examinations and age-appropriate immunizations. Professional services which are furnished by a non-PPO provider are payable at the non-PPO physician level, and are subject to separate out-of-network coinsurance and expense limitation requirements. Dental services, hospice care services, mental illness or substance abuse services and organ and tissue transplant services are not included as professional services, except as specifically provided under items No. 11, 16, 17 or 18 below.

3. **Second surgical opinion**. If surgery has been recommended, you may be required by us to obtain a second opinion. For the Medicare Plan and the non-HDHP Plan options, any deductible or coinsurance for the second opinion will be waived. The HDHP Plan options do not require a second surgical opinion. However, if a second surgical opinion is obtained under these HDHP Plan options, benefits are subject to deductible and coinsurance requirements.

4. **Outpatient prescription drugs and medicines**. Regardless of which plan you are enrolled in, the following conditions must be met in order for CHIP coverage to apply: (a) prescription drugs and medicines cannot be used for cosmetic purposes (including, but not limited to, Retin A/Tretinoin and Minoxidil/Rogaine); (b) prescription drugs and medicines must require, by federal law, a prescription written by a Physician as part of your treatment; and (c) prescription drugs and medicines must be Medically Necessary. There are no benefits for any devices or appliances, or any charges that you may incur for the administration of

outpatient prescription drugs and medicines.

Different benefits apply for prescription drugs and medicines, based on which plan you are enrolled in:

a) The Medicare Plan. If you are enrolled in the Medicare Plan, there are no benefits available for drugs and medicines unless the prescription drug is covered under either Medicare Part A or Part B. Prescriptions covered under Medicare Part D are not covered under the Medicare Plan.

b) The Non-HDHP Plans. If you are enrolled in any of the non-HDHP Plan options, benefits will be provided for covered drugs and medicines purchased for your use as an outpatient from a participating pharmacy using the Plan's Prescription Drug Card Program. Insulin and insulin syringes are also covered, even though a prescription may not be required by law. There are no benefits for any prescriptions purchased from non-participating pharmacies or for any claims for prescription drugs that are not filed electronically using the Plan's Prescription Drug Card Program.

   Prescription drug benefits are provided only through a separate prescription drug card program in lieu of any major medical prescription drug benefits. With this prescription drug card program, participants pay a separate prescription drug card co-pay of 20% per prescription of the cost of any covered generic and brand prescriptions, subject to certain minimums, maximums and other limitations. Participants do not have to satisfy any deductible in order to receive benefits under this prescription drug card program.

   The 20% co-pay per prescription requirement for this prescription drug card program is applicable to all covered outpatient prescription drugs, whether purchased through a retail participating pharmacy or a mail participating pharmacy. Benefits for each retail prescription are limited to a 30 consecutive day supply of that drug. Benefits for each mail service prescription are limited to a 90 consecutive day supply of that drug. The minimum co-pay charged by the Plan is $5 per prescription for up to a 30 day supply and $10 per prescription for between a 31 day supply and a 90 day supply. The maximum co-pay charged by the Plan is $100 per prescription for up to a 30 day supply and $200 per prescription for between a 31 day supply and a 90 day supply.

   There is a $2,500 calendar year out-of-pocket maximum or stop-loss limit on the co-pays for these prescription drug card program benefits. If you choose a brand prescription drug when a generic equivalent is available, you will be responsible for the 20% co-payment plus the difference in the cost between the brand drug and its generic equivalent. Only the 20% co-payment will be applied toward your $2,500 calendar year maximum out-of-pocket for prescription drugs; the difference in the cost between the brand drug and its generic equivalent is solely your responsibility to pay, and will NOT be applied toward your $2,500 calendar year maximum out-of-pocket.

   Maximum co-payment and maximum out-of-pocket amounts exclude the difference between the generic and brand drug cost. The participant is responsible for paying this difference if a brand drug is selected when a

generic equivalent is available. This amount is in addition to the 20% co-payment.

The prescription drug card co-pays are based upon the discounted charges negotiated by the Prescription Drug Administrator. The prescription drug card co-pays do not apply toward the participant's major medical deductible or out-of-pocket expense amount. Any benefits that are paid under this prescription drug card program will be applied to the participant's combined medical and drug lifetime maximum benefit of $2 million ($1.5 million after August 28, 2010).

c) The HDHP Plan options. If you are enrolled in any of the HDHP plans, benefits will be provided for covered drugs and medicines purchased for your use as an outpatient from a participating pharmacy using the Plan's Prescription Drug Card Program. Insulin and insulin syringes are also covered, even though a prescription may not be required by law. There are no benefits for any prescriptions purchased from non-participating pharmacies or for any claims for prescription drugs that are not filed electronically using the Plan's Prescription Drug Card Program.

Prescription drug benefits are provided only through the prescription drug card program. With this prescription drug card program, participants pay a prescription drug card co-pay of 20% per prescription of the cost of any covered generic and brand prescription, subject to certain minimums, maximums and other limitations. Participants must first satisfy their deductible before they can receive any benefits under these HDHP programs.

The 20% co-pay per prescription requirement for this prescription drug card program is applicable to all covered outpatient prescription drugs, whether purchased through a retail participating pharmacy or a mail participating pharmacy. Benefits for each retail prescription are limited to a 30 consecutive day supply of that drug. Benefits for each mail service prescription are limited to a 90 consecutive day supply of that drug. The minimum co-pay charged by the Plan is $5 per prescription for up to a 30 day supply and $10 per prescription for between a 31 day supply and a 90 day supply. The maximum co-pay charged by the Plan is $100 per prescription for up to a 30 day supply and $200 per prescription for between a 31 day supply and a 90 day supply.

If you choose a brand prescription drug when a generic equivalent is available, you will be responsible for the 20% co-payment plus the difference in the cost between the brand drug and its generic equivalent. The difference in the cost between the brand drug and its generic equivalent is solely your responsibility to pay, and will NOT be applied toward any calendar year maximum out-of-pocket.

Maximum co-payment and maximum out-of-pocket amounts exclude the difference between the generic and brand drug cost. The participant is responsible for paying this difference if a brand drug is selected when a generic equivalent is available. This amount is in addition to the 20% co-payment.

The prescription drug card co-pays are based upon the discounted charges negotiated by the Prescription Drug Administrator. Once the calendar year

deductible has been met, the prescription drug card co-pays do apply toward the participant's out-of-pocket expense amount. Any benefits that are paid under this prescription drug card program will be applied to the participant's combined medical and drug lifetime maximum benefit of $2 million ($1.5 million after August 28, 2010).

4. **Use of radium or other radioactive materials**. Lower benefits will apply if a non-PPO provider is used.

6. **Oxygen and its administration**. Lower benefits will apply if a non-PPO provider is used.

7. **Administration of anesthesia**. Lower benefits will apply if a non-PPO provider is used.

8. **Orthoses or prostheses other than dental** which are determined to be medically necessary by our Administrator. Specific limitations apply. Lower benefits will apply if a non-PPO provider is used.

9. **Durable Medical Equipment.** Purchase or rental (up to the purchase price) of medically necessary durable medical equipment, other than eyeglasses or hearing aids, that:

   a) is used for therapeutic purposes and that has no personal use in the absence of the condition for which it is prescribed;

   b) is approved by the Administrator in advance if it costs $500 or more per item;

   c) is prescribed by the attending physician;

   d) is appropriate for home use; and

   e) is used to serve a medical purpose apart from transportation, comfort or convenience.

   All of the above conditions must be met in order to be considered an eligible covered service or supply. If you are considering making periodic payments to rent an item, ask your physician for an estimate of the length of time you will require the use of the equipment. If the periodic rental rate multiplied by the period of time you will need the equipment exceeds the cost of purchasing the equipment, you should consider purchasing that equipment since in no case will benefits ever exceed the purchase price of the equipment.

   Without prior written approval from our Administrator before you purchase or rent durable medical equipment costing $500 or more per item, no benefits are payable and this equipment will not be covered.

10. **Diagnostic services**, including (a) an annual mammogram for women age 40 and older; (b) an annual cervical smear or pap smear test for women; (c) an annual digital rectal examination and a prostate-specific antigen test for men age 40 and older upon the recommendation of a physician; and (d) colorectal cancer screening once every 3 years for any covered person age 50 and older. Lower benefits will apply if a non-PPO provider is used.

11. **Limited Oral Surgical Services** that are required (a) for excision of partially or completely unerupted impacted teeth when not performed in connection with the routine extraction or repair of teeth; (b) for excision of tumors or cysts of the jaws,

cheeks, lips, tongue, and roof and floor of the mouth; (c) for correction of cleft lip and palate and other craniofacial and maxillofacial birth defects; or (d) to treat injury to natural teeth or a fractured jaw due to an accident. No other dental or oral surgical services are covered. Lower benefits will apply if a non-PPO provider is used.

12. **Physical, speech or functional occupational therapy**, as medically necessary, in the judgment of our Administrator, and provided by an appropriately licensed professional, with limitations. Lower benefits will apply if a non-PPO provider is used. Maintenance physical, speech or occupational therapy, i.e. therapy administered to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur, is not covered.

13. **Emergency and other medically necessary transportation** provided by a licensed ambulance service, with limitations.

14. **Skilled Nursing Facility Care**. While confined and receiving skilled nursing services in a skilled nursing facility, benefits will be payable only for: (a) bed, board and skilled nursing services at the most common semi-private room rate; and (b) ancillary services such as drugs and surgical dressings or supplies furnished for medical care therein. Benefits are limited to 120 days of confinement each calendar year. Lower benefits will apply if a non-PPO provider is used. There are no benefits for services received in an uncertified skilled nursing facility. **Preadmission review required.**

15. **Home Health Care**. Benefits are limited to 270 visits per calendar year for home health care services provided in lieu of any hospitalization or confinement in a skilled nursing care facility with certain limitations. Home health care services must be ordered by your attending physician, and furnished in your home by a home health agency under a Home Health Care Plan which has been approved in advance by our Administrator. Each visit by a registered nurse (RN), licensed practical nurse (LPN), licensed therapist or home health aide for up to four consecutive hours counts as one home health care visit. Lower benefits will apply if a non-PPO provider is used. **Without written prior approval from our Administrator, these services will not be covered.**

16. **Hospice Care**. Benefits are available for the hospice care program services you receive under a written program prescribed by your attending physician and approved in advance by our Administrator, with certain limitations, for up to 180 days per calendar year. Lower benefits will apply if a non-PPO provider is used. See the specific CHIP benefit plan booklet for details. **Without prior written approval from our Administrator, these services will not be covered.**

17. **Mental Illness or Substance Abuse Rehabilitation Treatment.** Benefits are available for the diagnosis and treatment of a mental illness or for substance abuse rehabilitation treatment, subject to limitations, when provided by (a) a physician; or (b) a psychologist or clinical social worker working within the scope of their license, as follows:

    a) Inpatient Treatment of Mental Illness - Benefits for inpatient confinement in a hospital for treatment of mental illness will be paid the same as any other covered sickness for up to a combined total of 45 days in any calendar year for inpatient treatment of mental illness, substance abuse rehabilitation

treatment program and any other out-of-state hospital confinements as described in Item 1. If such confinement is in a non-PPO hospital, payment will be at the non-PPO hospital level, and will be subject to separate out-of-network co-payment and expense limitation requirements. If you are enrolled in the Medicare Plan, the Traditional Plan, or the Traditional HDHP Plan, benefits for confinement in a hospital which is located within the State of Illinois will be paid the same as any other covered sickness. **Preadmission review required.**

b) Partial Hospitalization Treatment Program – benefits are available for this program immediately following an inpatient hospital stay for the treatment of mental illness, but only if it is approved in advance in writing by our Administrator. Your treatment for mental illness under an approved program is considered a continuation of that stay, and two partial days will count as though it were one inpatient day. Lower benefits will apply if a non-PPO provider is used. No benefits will be provided for services rendered in a partial hospitalization treatment program that has not been approved by the Administrator: (a) following an inpatient stay in the same or different hospital; or (b) by direct admission to an approved program. **Without prior written approval from our Administrator, these services will not be covered.**

c) Substance Abuse Rehabilitation Treatment Program - benefits are available for covered expenses for substance abuse rehabilitation treatment, but only if these services are provided in a substance abuse rehabilitation treatment program which has been approved in writing in advance by the Administrator, up to a combined total of 45 days in any calendar year for inpatient treatment of mental illness, partial hospitalization treatment program and substance abuse rehabilitation treatment program, and subject to the other limitations as further provided under Item 1. **Without prior written approval from our Administrator, these services will not be covered.**

d) Outpatient Treatment of Mental Illness or Substance Abuse Treatment Program - benefits are available for outpatient treatment of mental illness or outpatient substance abuse rehabilitation treatment in a program approved by the Administrator. Lower benefits will apply if a non-PPO provider is used. Benefits for outpatient treatment of mental illness and outpatient substance abuse rehabilitation treatment are limited to a combined total of up to 50 visits in any calendar year. None of the charges for outpatient treatment of mental illness or substance abuse rehabilitation treatment will be included in the calculation of your out-of-pocket expense amount or out-of-network expense limitation.

18. **Specified Organ or Tissue Transplant Benefits**. CHIP will cover only covered services for those organ or tissue transplants that:

a) are specified under Coverage for Specified Organ or Tissue Transplants;

b) have prior written approval from our Administrator;

c) are determined by our Administrator to be medically necessary; and

d) meet all of the terms and conditions under Coverage for Specified Organ or Tissue Transplants in any specific CHIP benefit plan booklet that may be issued to you.

COST CONTAINMENT PROVISIONS

Expenses for medical care are covered only if the care is medically necessary. A utilization review (UR) program has been established by our Administrator to perform preadmission review of covered services for inpatient confinement in a hospital or skilled nursing care facility prior to such services being rendered; review requests for prior approval when required by your CHIP coverage; and coordinate a program for length of stay/service review. The purpose of these services is to determine whether the confinement or surgery is medically necessary. Any non-emergency admission to a hospital or skilled nursing facility as an inpatient must be precertified by the Administrator's UR program. Different rules apply for emergency confinements. Refer to any specific CHIP benefit plan booklet that may be issued to you for details.

These provisions of your CHIP coverage are designed to insure that you get all the necessary care you need in the most appropriate setting while preventing unnecessary procedures and confinements that increase your charges but provide no benefit to you. They also enable our Administrator's UR program to help plan your discharge to your home or a skilled nursing facility while determining whether any post-hospitalization care is covered by your CHIP coverage. Precertification or prior approval does not constitute a guarantee of benefits under your CHIP coverage for any confinements that are precertified by the UR program as medically appropriate. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of your CHIP coverage, including any preexisting conditions limitation.

1. **Preadmission Review of Inpatient Confinements**. Preadmission review is required when you are confined in a hospital or skilled nursing facility for:
   a) expenses incurred for days of confinement certified as medically appropriate, benefits will be payable in accord with the provisions set forth in the specific CHIP benefit plan booklet;
   b) expenses incurred for days of confinement for which review does occur, but which are not certified as medically appropriate, benefits for room and board will not be payable, and benefits for other covered services will be payable in accord with the provisions set forth in the specific CHIP benefit plan booklet;
   c) expenses incurred for days of confinement at a facility which is located within either the State of Illinois or not more than 75 miles outside the State of Illinois for which review does not occur, in addition to any penalty imposed under item b) above, benefits will be reduced by $500; and
   d) expenses incurred for days of confinement and any other related professional medical services at a facility which is located more than 75 miles outside the State of Illinois for which review does not occur, in addition to any penalty imposed under item b) above, benefits also will be reduced by 20% of the rate of payment which would have been payable had prior approval been received.

   Any reduction in benefits described above cannot be used to satisfy any

deductible, out-of-pocket expense amount or out-of-network expense limit contained in the specific CHIP benefit plan booklet.

Benefits will not be payable when days of confinement in a hospital or skilled nursing facility are for medical or surgical services which are not: (a) medically necessary; or (b) covered by your CHIP coverage.

2. **Hospital Preadmission Testing**. For the Medicare Plan, and the non-HDHP Plans, expenses for hospital preadmission testing will be paid at 100% of usual and customary fees with no deductible if:
   a) your physician determines that hospital confinement is necessary before the tests are performed;
   b) tests are performed on an outpatient basis in connection with a covered hospital confinement within seven days of admission to a hospital as an inpatient;
   c) the tests would be covered if performed during hospital confinement; and
   d) the hospital where you are confined accepts the tests in lieu of tests which would have been performed during hospital confinement, and does not repeat the tests upon admission, unless your medical records show both the results of the preadmission tests and that repeated tests are medically necessary.

   Hospital pre-admission testing benefits are payable same as any other medical tests (i.e., subject to the deductible and coinsurance) under the HDHP Plans.

3. **Prior Approval**. Prior approval is required in each of the following instances. Prior approval requires you to notify the Administrator's UR by phone prior to receiving a service, drug or supply:
   a) Durable Medical Equipment: If you intend to purchase or rent durable medical equipment, check first to see if the total overall cost of the item will be $500 or more. If so, prior approval is required. **If written prior approval is not obtained from our Administrator, any expense incurred for the purchase or rental of durable medical equipment will not be covered.**
   b) Home Health Care: If your attending physician has ordered a plan of treatment for home health care, you must obtain prior approval. **If prior approval is not obtained from our Administrator, any expense incurred as a result of home health care will not be covered.**
   c) Hospice Care: If your attending physician has ordered hospice care, you must obtain prior approval. **If prior approval is not obtained from our Administrator, any expense incurred as a result of hospice care will not be covered.**
   d) Specified Organ or Tissue Transplants: To be eligible for benefits for any specified organ or tissue transplant (see next section), you must obtain our Administrator's prior written approval and use a Board-approved participating transplant center for that specific organ or tissue transplant. **We will pay no benefits unless you have obtained prior approval in writing from our Administrator and comply with all of the terms, conditions and other requirements provided for in any specific CHIP benefit plan booklet that may be issued to you.**

COVERAGE FOR SPECIFIED ORGAN OR TISSUE TRANSPLANTS

Only the human organ or tissue transplants specified below will be covered under your CHIP coverage subject to the exclusions, limitations and requirements set forth in any CHIP benefit plan booklet that may be issued to you:

1. Cornea;
2. Liver;
3. Heart;
4. Heart-lung;
5. Lung;
6. Kidney except for covered persons with permanent kidney failure and end-stage renal disease (who will be eligible for Medicare coverage);
7. Simultaneous kidney/pancreas;
8. Pancreas;
9. Allogenic (homologous) bone marrow for the treatment of:
   a) acute leukemia or chronic myelogenous leukemia;
   b) aplastic anemia;
   c) severe combined immunodeficiency disease (SCID); or
   d) Wiskott-Aldrich syndrome;
   e) infantile malignant osteopetrosis;
   f) non-Hodgkin's lymphoma;
   g) Hodgkin's Disease;
   h) neuroblastoma, stage III or IV; or
   i) lysosomal storage disorders;
10. Autologous bone marrow for the treatment of:
    a) acute lymphocytic or non-lymphocytic leukemias following a first or subsequent relapse;
    b) resistant non-Hodgkin's lymphoma with evidence of relapse or resistance and:
       i. you have adequate marrow functions and no evidence of marrow involvement by lymphoma;
       ii. you do not have a concurrent condition which would seriously jeopardize the achievement of a curable completed remission with this treatment;
    c) recurrent or refractory neuroblastoma Stage III or IV, when:
       i. you are one for whom further treatment with a conventional dose therapy is not as likely to achieve a durable remission (e.g., a patient who relapses after a complete remission was achieved with a second treatment of conventional dose chemotherapy where no alternative conventional-dose regimen is expected to achieve a durable remission);
       ii. you have adequate marrow function and no evidence of marrow involvement by Hodgkin's Disease or Neuroblastoma;
       iii. you do not have a concurrent condition which would seriously jeopardize the achievement of a durable complete remission with this treatment;
    d) advanced Hodgkin's disease, relapsed or resistant, in those who have failed conventional therapy and have no HLA-matched donor;

e) germ cell tumors, including testicular and ovarian cancers that are demonstrated to be refractory to standard chemotherapy;
f) multiple myeloma; or
g) breast cancer, stage II, III, or IV when there is documentation that the malignancy is not responsive to conventional doses of chemotherapy; or

11. peripheral stem cell harvest as a substitute for any clinical indication noted above under (j) autologous bone marrow.

Any organ or tissue transplant that is not specifically listed in your CHIP benefit plan booklet as a covered transplant is not covered. Implantations of any artificial organs or devices, or non-human transplants, are also not covered.

To be covered by CHIP, any organ or tissue transplant or related expenses including an evaluation for a transplant must receive our Administrator's prior written approval and be performed at a hospital designated by the Board as a participating transplant center for your specified organ or tissue transplant. Written approval from the Administrator prior to the scheduling of organ or tissue transplant surgery and use of a participating transplant center are conditions of the benefits provided by your CHIP coverage.

No benefits will be payable for any specific organ or tissue transplant not performed at a participating transplant center for that specific organ or tissue transplant.

The list of specific organ or tissue transplants covered by CHIP and/or hospitals designated by the Board as participating transplant centers are periodically reviewed and may change from time to time. For information on the current list of organ-specific participating transplant centers, contact the Administrator at 800-232-6179 or the Board Office at 217-782-6333.

MATERNITY BENEFITS

All Section 15 Plans (HIPAA and HCTC) automatically cover expenses of the insured person related to maternity.

For the Traditional and Medicare Plans, a rider providing an optional benefit for routine maternity expenses, which are not otherwise covered by CHIP, is available. This rider is available only at the time of initial application or within 60 days from the date of marriage, and requires payment of additional premium. This optional benefit is payable for hospital confinement or for treatment by a physician in relation to normal maternity care occurring while this optional maternity coverage is in force. Benefits will be provided for normal maternity care more than nine months after this optional maternity coverage takes effect. This benefit is also payable for maternity care in relation to premature birth, free of complications, provided a full-term pregnancy would have resulted in childbirth more than nine months after this optional maternity coverage takes effect.

Refer to the rate tables to determine the cost of adding this optional maternity rider to the Traditional and Medicare plans.

EXCLUSIONS – WHAT IS NOT COVERED BY CHIP

CHIP will not pay for any expense or charge:

1. for any services or supplies which are not, in the judgment of our Administrator, medically necessary or not recommended by a physician. Our Administrator will make the decision whether hospitalization or health care services or supplies were not medically necessary and therefore not eligible charges under the terms of your CHIP coverage;
2. for room and board or for services rendered or articles prescribed by a physician, dentist, or other provider that exceeds the usual and customary fee;
3. incurred prior to the effective date of your CHIP coverage or after your CHIP coverage ends;
4. for services and supplies which are primarily to provide rest or convalescence, are for custodial care services, or are for educational or domiciliary purposes;
5. requiring prior approval under the terms of your CHIP coverage if such prior approval is not obtained;
6. relating to a hospital admission for diagnostic services that may be performed on an outpatient basis;
7. which is incurred while you are on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and for which any governmental body or its agencies are liable;
8. for personal supplies or services provided by a hospital or skilled nursing facility or any other service, drug or supply which is non-medical in nature or can be obtained without a prescription;
9. for services of any blood donors, any fee for failure to replace the first 3 pints of blood provided to you for each calendar year, and blood derivatives which are not classified as drugs in the official formularies;
10. for maternity services, including related services and supplies, for the Traditional and Medicare plans, except for complications of pregnancy (Maternity services **are** covered under the Section 15 Plans);
11. for obtaining an abortion, induced miscarriage or induced premature birth unless in the opinion of the attending physician:
    a) such procedures are necessary for the preservation of life of the woman seeking such treatment; or
    b) an induced premature birth is intended to produce a live viable child and such procedure is necessary for the health of the mother or the unborn child;
12. for services or articles the provision of which is not within the scope of licensure of the institution or individual providing the services or articles;
13. for: (a) routine extraction or repair of teeth; (b) procedures, including orthodontics and prosthetics, necessary for craniofacial or maxillofacial conditions; (c) services relating to the diagnosis, treatment and appliance of temporomandibular joint disorders or syndromes (TMJ) and other myofunctional disorders; or (d) dental services, including dental care, dental surgery, dental treatment, any other dental procedure involving the teeth or periodontium or any dental appliance, including crowns, bridges, implants, or partial or complete dentures, except as specifically provided for under oral surgical services;

14. for eyeglasses, contact lenses, or hearing aids; examinations for the prescription or fitting of eyeglasses, contact lenses, hearing aids; or for the determination of the refractive errors of the eyes, or auditory problems;
15. for cosmetic or reconstructive surgery and related services and supplies, or treatment for cosmetic purposes other than for reconstructive surgery when such service is incidental to or follows surgery resulting from injury or sickness or other diseases of the involved part or surgery for the repair or treatment of a congenital bodily defect to restore normal bodily functions;
16. for services, drugs or supplies that are:
    a) not provided in accordance with generally accepted standards of current medical practice;
    b) for procedures, treatments, equipment, devices, transplants or implants any of which are investigational, experimental, or furnished in connection with research purposes; or
    c) investigative and not proven safe and effective;
17. for services, drugs or supplies that are for, or resulting from, surgery or surgeries performed in connection with sexual reassignment or gender transformation;
18. for services or supplies for which you are not required to make payment, for which a charge is not made in the absence of insurance or for which there is no legal obligation on your part to pay if you did not have this or similar coverage;
19. for any services or supplies that are furnished to you by a local, state or federal government or for any services or supplies to the extent payment or benefits are provided or available to you under the laws of the United States or the State of Illinois, including Medicare, Medical Assistance, the Division of Specialized Care for Children of the University of Illinois or other maternal and child health services, any program that is administered or funded by the Illinois Department of Human Services, Illinois Department of Healthcare and Family Services, Illinois Department of Public Health or similar agencies in any other state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act, military service-connected disability payments, medical services provided for current or retired members of the Armed Forces and their dependents or employees of the Armed Forces of the United States, any medical services financed on behalf of all citizens by the United States, or as otherwise provided by law, whether or not that payment or benefit is received;
20. any services and supplies rendered or provided for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;
21. for oral contraceptives used for birth control or any other temporary birth control measures;
22. for sterilization or sterilization reversals;
23. for weight loss programs, exercise equipment, or treatment of obesity, except when certified by a physician as morbid obesity (at least two times normal body weight);
24. for acupuncture treatment unless used as an anesthetic agent for a covered surgery;
25. for or related to organ or tissue transplants other than those that are specifically listed as covered in Coverage for Specified Organ or Tissue Transplants, are

performed at a hospital with a Board-approved organ or tissue transplant program that has been designated by the Board as a participating transplant center for that specific organ or tissue, and meet all of the terms and conditions of your CHIP coverage;

26. for procedures, treatments, equipment or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community;
27. resulting from your voluntary participation in a riot or from your commission of, or attempt to commit, a felony;
28. for services, drugs and supplies for any sickness or injury which results from an act of declared or undeclared war;
29. for a service rendered by a professional provider, dentist, nurse, pharmacist, or other licensed professional if such professional provider, dentist, nurse, pharmacist, or other licensed professional is you; a person who lives with you; your spouse; or a child, brother, sister or parent of you or your spouse;
30. incurred outside the United States for medical treatment, services, drugs or supplies on a date in excess of thirty (30) days from the date the first charge was incurred in a foreign location. However, no benefits will be paid if you traveled to a foreign location for the purpose of obtaining medical treatment, services, drugs, supplies, or equipment;
31. for routine physical examinations, immunizations, or tests, sports-related health check-ups, employer-required health check-ups, and other check-ups not connected with sickness or injury, pre-marital examinations, surveys, casefinding, research studies, screening, or similar procedures and studies except as otherwise specifically provided under the terms of your CHIP coverage;
32. for the procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury;
33. for services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other anti-social activities which are not specifically the result of a mental illness;
34. for services or supplies received from a dental or medical department or clinic maintained by an employer, labor union, university or other similar person or group;
35. for personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as meals, undergarments, special toilet seats, non-hospital type adjustable beds, air conditioners, air purifiers, humidifiers, dehumidifiers, physical fitness equipment, chair, van or stair lifts, televisions, telephones and computers;
36. for maintenance occupational therapy, maintenance physical therapy, or maintenance speech therapy;

37. for services or supplies for any sickness or injury for which benefits are available to you under any workers' compensation or occupational disease act or other similar laws, except where not required by law;
38. for skilled nursing facility, extended care and hospital room and board charges for days when the bed has not been occupied by a covered person (holding charges);
39. for court mandated services, if not a covered service under your CHIP coverage or not considered to be medically necessary by the Plan Administrator;
40. for failure to keep a scheduled visit, or for completion of claim forms; for outpatient prescription drugs obtained from a Non-Participating Pharmacy or for any prescription that is not submitted electronically; or
41. for any other services, drugs or supplies that are not specifically mentioned as covered under the terms of your CHIP coverage.

TERMINATION OF CHIP COVERAGE

Your CHIP coverage will terminate on the earliest of:

1. the date you are no longer a United States citizen or a lawful permanent resident alien;
2. the date you are no longer, for purposes of qualifying for and participating in CHIP, a resident of Illinois;
3. 30 days after the date we make an inquiry concerning your eligibility for CHIP or your place of residence to which you do not reply;
4. the date you first receive or are approved to receive medical assistance (Medicaid) from the Illinois Department of Healthcare and Family Services or a similar agency in any other State (for Medicaid/medical assistance recipients, see paragraph regarding the medical assistance spenddown program);
5. the date you request your coverage to end, provided we receive your written request prior to such date;
6. for the Medicare Plan, and the Traditional Plans, the date you become a resident of a public institution;
7. the latest service date for which benefits have been paid that cause you to meet your Lifetime Maximum in benefits from CHIP;
8. the date you are or were ineligible for CHIP coverage under state or federal law;
9. for the Medicare Plan and the Traditional Plans, the first date you are **eligible**, as an insured employee, participant, enrollee, member or covered individual, or as a dependent of any such individual, for any other coverage which we determine provides basic benefits substantially similar to or better than the CHIP coverage as described in your CHIP benefit plan booklet, and: (a) you have satisfied any preexisting condition limitation under your CHIP coverage; or (b) you have or would have satisfied any preexisting condition exclusion under this other coverage which you are eligible for or are able to obtain to replace your CHIP coverage;
10. for the Traditional Plan, and the HIPAA-HCTC Plans, on the date you are **eligible** for Medicare Parts A and B for any reason. The HIPAA Plan, including

the HIPAA-HDHP Plan, will terminate on the date you are **eligible** for Medicare Parts A and B for any reason and you have satisfied the preexisting condition limitation that would apply to the Medicare Plan. The Medicare Plan will terminate on the date you are no longer enrolled in Parts A and/or B of Medicare. In no event will any plan coverage remain in force past the first of the month coincident with the date you become eligible for Medicare due to age unless: (a) you are not eligible for Medicare Parts A and B; or (b) you were born before November 1, 1926;

11. for the Medicare Plan and the Traditional Plans, the first date of any term for which your premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of such employee, of a government agency or health care provider;
12. for the Medicare Plan and the Traditional Plans, the date you receive benefits or funds from any settlement, judgment, or award resulting from any accident or injury or other circumstance, regardless of the date of the accident or injury, or any other circumstances creating a legal liability for damages due you by a third party, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable, to you, your dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or assets remaining from those sources in an amount in excess of $300,000;
13. the date you knowingly and willfully obtained or attempted to obtain, or fraudulently aided or attempted to aid any other person in obtaining, any coverage or benefits under CHIP to which you or that other person were not entitled;
14. the date your coverage under any health benefit program as defined in federal criminal law on healthcare offenses (18 U.S.C. 24), including any public or private plan or contract under which any medical benefit, item, or service is provided, was terminated as a result of any act or practice that constitutes fraud under state or federal law or as a result of an intentional misrepresentation of material fact, and that act or practice occurred within the time period beginning five years prior to the date your CHIP eligibility and enrollment form was received by the Board up to the present;
15. the date we terminate the CHIP coverage of all covered persons within the same class, form or benefit plan as you;
16. for the HIPAA-HCTC Plans, the date the primary person is no longer an HCTC certified person;
17. the date your CHIP coverage otherwise ends due to nonpayment of the required renewal premium; or
18. the date of your death.

Upon termination of your CHIP coverage, you will be issued a certificate of creditable coverage. You may request a certificate of creditable coverage within 24 months of the termination of your or your dependent's (if applicable) CHIP coverage.

We will refund any premium paid for the period after the date of termination less the amount of all claims paid for that same period.

We will pay benefits for all covered expenses as described in your CHIP benefit plan booklet which are incurred before your CHIP coverage terminates. We will not pay benefits for expenses incurred after your CHIP coverage terminates.

Office of the Board of Directors
Illinois Comprehensive Health Insurance Plan
320 West Washington Street, Suite 700
Springfield, IL 62701-1150

For further information about CHIP coverage and how to apply, call, write or visit our web site:

Office of the Board of Directors
Illinois Comprehensive Health Insurance Plan
320 West Washington Street, Suite 700
Springfield, IL 62701-1150
(217) 782-6333 (Voice)
1-800-962-8384 (toll-free in Illinois)
www.chip.state.il.us

Major Medical Administrator

Blue Cross and Blue Shield of Illinois
1-800-367-6410 (toll-free voice)
1-800-545-2455- Hearing Impaired (TTY)

Prescription Drug Administrator

Walgreens Health Initiatives
1-800-207-2568 (toll-free voice)

ILLINOIS RESPONSE TO HHS TEMPORARY HIGH RISK POOL SOLICITATION

APPENDIX B:

CHIP Act

INSURANCE

(215 ILCS 105/)

Comprehensive Health Insurance Plan Act.

(215 ILCS 105/1) (from Ch. 73, par. 1301)

Sec. 1. Short Title. This Act shall be known and may be cited as the Comprehensive Health Insurance Plan Act.

(Source: P.A. 84-1478.)

(215 ILCS 105/1.1) (from Ch. 73, par. 1301.1)

Sec. 1.1. The General Assembly hereby makes the following findings and declarations:

(a) The Comprehensive Health Insurance Plan is established as a State program that is intended to provide an alternate market for health insurance for certain uninsurable Illinois residents, and further is intended to provide an acceptable alternative mechanism as described in the federal Health Insurance Portability and Accountability Act of 1996 for providing portable and accessible individual health insurance coverage for federally eligible individuals as defined in this Act.

(b) The State of Illinois may subsidize the cost of health insurance coverage offered by the Plan. However, since the State has only a limited amount of resources, the General Assembly declares that it intends for this program to provide portable and accessible individual health insurance coverage for every federally eligible individual who qualifies for coverage in accordance with Section 15 of this Act, but does not intend for every eligible person who qualifies for Plan coverage in accordance with Section 7 of this Act to be guaranteed a right to be issued a policy under this Plan as a matter of entitlement.

(c) The Comprehensive Health Insurance Plan Board shall operate the Plan in a manner so that the estimated cost of the program during any fiscal year will not exceed the total income it expects to receive from policy premiums, investment income, assessments, or fees collected or received by the Board and other funds which are made available from appropriations for the Plan by the General Assembly for that fiscal year.

(Source: P.A. 90-30, eff. 7-1-97.)

(215 ILCS 105/2) (from Ch. 73, par. 1302)

Sec. 2. Definitions. As used in this Act, unless the context otherwise

requires:

"Plan administrator" means the insurer or third party administrator designated under Section 5 of this Act.

"Benefits plan" means the coverage to be offered by the Plan to eligible persons and federally eligible individuals pursuant to this Act.

"Board" means the Illinois Comprehensive Health Insurance Board.

"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, Sections 367.2, 367e, and 367e.1 of the Illinois Insurance Code, or any other similar requirement in another State.

"Covered person" means a person who is and continues to remain eligible for Plan coverage and is covered under one of the benefit plans offered by the Plan.

"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 Section 104 of the Health Care 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 Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(K) Any other qualifying coverage required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or regulations under that Act.

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 2791(c) of title XXVII of the Public Health Service Act (42 U.S.C. 300 gg-91), nor does it include any period of coverage under any of items (A) through (K) that occurred before a break of more than 90 days or, if the individual has been certified as eligible

pursuant to the federal Trade Act of 2002, a break of more than 63 days during all of which the individual was not covered under any of items (A) through (K) 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 90 days in any creditable coverage.

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is claimed as a dependent by the principal insured for purposes of filing a federal income tax return and resides in the principal insured's household, and is a resident unmarried child under the age of 19 years; or who is an unmarried child who also is a full-time student under the age of 23 years and who is financially dependent upon the principal insured; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

"Direct Illinois premiums" means, for Illinois business, an insurer's direct premium income for the kinds of business described in clause (b) of Class 1 or clause (a) of Class 2 of Section 4 of the Illinois Insurance Code, and direct premium income of a health maintenance organization or a voluntary health services plan, except it shall not include credit health insurance as defined in Article IX 1/2 of the Illinois Insurance Code.

"Director" means the Director of the Illinois Department of Insurance.

"Effective date of medical assistance" means the date that eligibility for medical assistance for a person is approved by the Department of Human Services or the Department of Healthcare and Family Services, except when the Department of Human Services or the Department of Healthcare and Family Services determines eligibility retroactively. In such circumstances, the effective date of the medical assistance is the date the Department of Human Services or the Department of Healthcare and Family Services determines the person to be eligible for medical assistance.

"Eligible person" means a resident of this State who qualifies for Plan coverage under Section 7 of this Act.

"Employee" means a resident of this State who is employed by an employer or has entered into the employment of or works under contract or service of an employer including the officers, managers and employees of subsidiary or affiliated corporations and the individual proprietors, partners and employees of affiliated individuals and firms when the business of the subsidiary or affiliated corporations, firms or individuals is controlled by a common employer through stock ownership, contract, or otherwise.

"Employer" means any individual, partnership, association, corporation, business trust, or any person or group of persons acting directly or indirectly in the interest of an employer in relation to an employee, for which one or more persons is gainfully employed.

"Family" coverage means the coverage provided by the Plan for the

covered person and his or her eligible dependents who also are covered persons.

"Federally eligible individual" means an individual resident of this State:

(1)(A) for whom, as of the date on which the individual seeks Plan coverage under Section 15 of this Act, the aggregate of the periods of creditable coverage is 18 or more months or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, 3 or more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) who is not eligible for coverage under (A) a group health plan (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), (B) part A or part B of Medicare due to age (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), or (C) medical assistance, and does not have other health insurance coverage (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002);

(3) with respect to whom (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) the most recent coverage within the coverage period described in paragraph (1)(A) of this definition was not terminated based upon a factor relating to nonpayment of premiums or fraud;

(4) if the individual (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

However, an individual who has been certified as eligible pursuant to the federal Trade Act of 2002 shall not be required to elect continuation coverage under a COBRA continuation provision or under a similar state program.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with that plan.

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

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

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and

including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization and a voluntary health services plan) that is authorized to transact health insurance business in this State. Such term does not include a group health plan.

"Health Maintenance Organization" means an organization as defined in the Health Maintenance Organization Act.

"Hospice" means a program as defined in and licensed under the Hospice Program Licensing Act.

"Hospital" means a duly licensed institution as defined in the Hospital Licensing Act, an institution that meets all comparable conditions and requirements in effect in the state in which it is located, or the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance.

"Insured" means any individual resident of this State who is eligible to receive benefits from any insurer (including health insurance coverage offered in connection with a group health plan) or health insurance issuer as defined in this Section.

"Insurer" means any insurance company authorized to transact health insurance business in this State and any corporation that provides medical services and is organized under the Voluntary Health Services Plans Act or the Health Maintenance Organization Act.

"Medical assistance" means the State medical assistance or medical assistance no grant (MANG) programs provided under Title XIX of the Social Security Act and Articles V (Medical Assistance) and VI (General Assistance) of the Illinois Public Aid Code (or any successor program) or under any similar program of health care benefits in a state other than Illinois.

"Medically necessary" means that a service, drug, or supply 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, drug, or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the covered person's medical

symptoms or condition cannot be safely provided to that person as an outpatient. A service, drug, or supply 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 patient, the patient's family, physician, hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that 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 covered person's condition or the quality of medical care; or (v) involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration.

"Medical care" means the ordinary and usual professional services rendered by a physician or other specified provider during a professional visit for treatment of an illness or injury.

"Medicare" means coverage under both Part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395, et seq.

"Minimum premium plan" means an arrangement whereby a specified amount of health care claims is self-funded, but the insurance company assumes the risk that claims will exceed that amount.

"Participating transplant center" means a hospital designated by the Board as a preferred or exclusive provider of services for one or more specified human organ or tissue transplants for which the hospital has signed an agreement with the Board to accept a transplant payment allowance for all expenses related to the transplant during a transplant benefit period.

"Physician" means a person licensed to practice medicine pursuant to the Medical Practice Act of 1987.

"Plan" means the Comprehensive Health Insurance Plan established by this Act.

"Plan of operation" means the plan of operation of the Plan, including articles, bylaws and operating rules, adopted by the board pursuant to this Act.

"Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, registered pharmacist acting within the scope of that registration, or any other person or entity licensed in Illinois to furnish medical care.

"Qualified high risk pool" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Resident" means a person who is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in this State that remains that person's principal residence and from which that person is absent only for temporary or transitory purpose.

"Skilled nursing facility" means a facility or that portion of a facility that is licensed by the Illinois Department of Public Health under the Nursing Home Care Act or a comparable licensing authority in another state to provide skilled nursing care.

"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.

"Third party administrator" means an administrator as defined in Section 511.101 of the Illinois Insurance Code who is licensed under Article XXXI 1/4 of that Code.

(Source: P.A. 95-965, eff. 9-23-08.)

(215 ILCS 105/3) (from Ch. 73, par. 1303)

Sec. 3. Operation of the Plan.

a. There is hereby created an Illinois Comprehensive Health Insurance Plan.

b. The Plan shall operate subject to the supervision and control of the board. The board is created as a political subdivision and body politic and corporate and, as such, is not a State agency. The board shall consist of 10 public members, appointed by the Governor with the advice and consent of the Senate.

Initial members shall be appointed to the Board by the Governor as follows: 2 members to serve until July 1, 1988, and until their successors are appointed and qualified; 2 members to serve until July 1, 1989, and until their successors are appointed and qualified; 3 members to serve until July 1, 1990, and until their successors are appointed and qualified; and 3 members to serve until July 1, 1991, and until their successors are appointed and qualified. As terms of initial members expire, their successors shall be appointed for terms to expire the first day in July 3 years thereafter, and until their successors are appointed and qualified.

Any vacancy in the Board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.

Any member of the Board may be removed by the Governor for neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

In addition, a representative of the Governor's Office of Management and Budget, a representative of the Office of the Attorney General and the Director or the Director's designated representative shall be members of the board. Four members of the General Assembly, one each appointed by the President and Minority Leader of the Senate and by the Speaker and Minority Leader of the House of Representatives, shall serve as nonvoting members of the board. At least 2 of the public members shall be individuals reasonably expected to qualify for coverage under the Plan, the parent or spouse of such an individual, or a surviving family member of an individual who could have qualified for the plan during his lifetime. The Director or Director's representative shall be the chairperson of the board. Members of the board shall receive no compensation, but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

c. The board shall make an annual report in September and shall file the report with the Secretary of the Senate and the Clerk of the House of

Representatives. The report shall summarize the activities of the Plan in the preceding calendar year, including net written and earned premiums, the expense of administration, the paid and incurred losses for the year and other information as may be requested by the General Assembly. The report shall also include analysis and recommendations regarding utilization review, quality assurance and access to cost effective quality health care.

d. In its plan of operation the board shall:

(1) Establish procedures for selecting a plan administrator in accordance with Section 5 of this Act.

(2) Establish procedures for the operation of the board.

(3) Create a Plan fund, under management of the board, to fund administrative, claim, and other expenses of the Plan.

(4) Establish procedures for the handling and accounting of assets and monies of the Plan.

(5) Develop and implement a program to publicize the existence of the Plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the Plan.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board immediately after completion of the review. The Department and the board shall retain all written complaints regarding the Plan for at least 3 years. Oral complaints shall be reduced to written form and maintained for at least 3 years.

(7) Provide for other matters as may be necessary and proper for the execution of its powers, duties and obligations under the Plan.

e. No later than 5 years after the Plan is operative the board and the Department shall conduct cooperatively a study of the Plan and the persons insured by the Plan to determine: (1) claims experience including a breakdown of medical conditions for which claims were paid; (2) whether availability of the Plan affected employment opportunities for participants; (3) whether availability of the Plan affected the receipt of medical assistance benefits by Plan participants; (4) whether a change occurred in the number of personal bankruptcies due to medical or other health related costs; (5) data regarding all complaints received about the Plan including its operation and services; (6) and any other significant observations regarding utilization of the Plan. The study shall culminate in a written report to be presented to the Governor, the President of the Senate, the Speaker of the House and the chairpersons of the House and Senate Insurance Committees. The report shall be filed with the Secretary of the Senate and the Clerk of the House of Representatives. The report shall also be available to members of the general public upon request.

(e-5) The board shall conduct a feasibility study of establishing a small employer health insurance pool in which employers may provide affordable

health insurance coverage to their employees. The board may contract with a private entity or enter into intergovernmental agreements with State agencies for the completion of all or part of the study. The study shall:

(i) Analyze other states' experience in establishing small employer health insurance pools;

(ii) Assess the need for a small employer health insurance pool, including the number of individuals who might benefit from it;

(iii) Recommend means of establishing a small employer health insurance pool; and

(iv) Estimate the cost of providing a small employer health insurance pool through the Illinois Comprehensive Health Insurance Plan or another, public or private entity.

The board may accept donations, in trust, from any legal source, public or private, for deposit into a trust account specifically created for expenditure, without the necessity of being appropriated, solely for the purpose of conducting all or part of the study. The board shall issue a report with recommendations to the Governor and the General Assembly by January 1, 2005. As used in this subsection e-5, "small employer" means an employer having between one and 50 employees.

f. The board may:

(1) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public in this State.

(2) Provide for reinsurance of risks incurred by the Plan and enter into reinsurance agreements with insurers to establish a reinsurance plan for risks of coverage described in the Plan, or obtain commercial reinsurance to reduce the risk of loss through the Plan.

(3) Issue additional types of health insurance policies to provide optional coverages as are otherwise permitted by this Act including a Medicare supplement policy designed to supplement Medicare.

(4) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission certification, second surgical opinion, concurrent utilization review programs, and individual case management for the purpose of making the pool more cost effective.

(5) Design, utilize, contract, or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(6) Adopt bylaws, rules, regulations, policies and procedures as may be necessary or convenient for the implementation of the Act and the operation of the Plan.

(7) Administer separate pools, separate accounts, or other plans or arrangements as required by this Act to separate federally

eligible individuals or groups of federally eligible individuals who qualify for plan coverage under Section 15 of this Act from eligible persons or groups of eligible persons who qualify for plan coverage under Section 7 of this Act and apportion the costs of the administration among such separate pools, separate accounts, or other plans or arrangements.

g. The Director may, by rule, establish additional powers and duties of the board and may adopt rules for any other purposes, including the operation of the Plan, as are necessary or proper to implement this Act.

h. The board is not liable for any obligation of the Plan. There is no liability on the part of any member or employee of the board or the Department, and no cause of action of any nature may arise against them, for any action taken or omission made by them in the performance of their powers and duties under this Act, unless the action or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

i. There is no liability on the part of any insurance producer for the failure of any applicant to be accepted by the Plan unless the failure of the applicant to be accepted by the Plan is due to an act or omission by the insurance producer which constitutes willful or wanton misconduct.

(Source: P.A. 92-597, eff. 6-28-02; 93-622, eff. 12-18-03; 93-824, eff. 7-28-04.)

(215 ILCS 105/4) (from Ch. 73, par. 1304)

Sec. 4. Powers and authority of the board. The board shall have the general powers and authority granted under the laws of this State to insurance companies licensed to transact health and accident insurance and in addition thereto, the specific authority to:

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Director, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions including, without limitation, utilization review and quality assurance programs, or with health maintenance organizations or preferred provider organizations for the provision of health care services.

b. Sue or be sued, including taking any legal actions necessary or proper.

c. Take such legal action as necessary to:

(1) avoid the payment of improper claims against the plan or the coverage provided by or through the plan;

(2) to recover any amounts erroneously or improperly paid by the plan;

(3) to recover any amounts paid by the plan as a result of a mistake of fact or law; or

(4) to recover or collect any other amounts,

including assessments, that are due or owed the Plan or have been billed on its or the Plan's behalf.

d. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves, and formulas and any other actuarial function appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

e. Issue policies of insurance in accordance with the requirements of this Act.

f. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the plan.

g. Borrow money to effect the purposes of the Illinois Comprehensive Health Insurance Plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets.

h. Establish rules, conditions and procedures for reinsuring risks under this Act.

i. Employ and fix the compensation of employees. Such employees may be paid on a warrant issued by the State Treasurer pursuant to a payroll voucher certified by the Board and drawn by the Comptroller against appropriations or trust funds held by the State Treasurer.

j. Enter into intergovernmental cooperation agreements with other agencies or entities of State government for the purpose of sharing the cost of providing health care services that are otherwise authorized by this Act for children who are both plan participants and eligible for financial assistance from the Division of Specialized Care for Children of the University of Illinois.

k. Establish conditions and procedures under which the plan may, if funds permit, discount or subsidize premium rates that are paid directly by senior citizens, as defined by the Board, and other plan participants, who are retired or unemployed and meet other qualifications.

l. Establish and maintain the Plan Fund authorized in Section 3 of this Act, which shall be divided into separate accounts, as follows:

(1) accounts to fund the administrative, claim, and other expenses of the Plan associated with eligible persons who qualify for Plan coverage under Section 7 of this Act, which shall consist of:

(A) premiums paid on behalf of covered persons;

(B) appropriated funds and other revenues collected or received by the Board;

(C) reserves for future losses maintained by the Board; and

(D) interest earnings from investment of the funds in the Plan Fund or any of its accounts other than the funds in the account established under item 2 of this subsection;

(2) an account, to be denominated the federally eligible individuals account, to fund the administrative, claim, and other expenses of the Plan associated with federally eligible individuals who qualify for Plan coverage under Section 15 of this Act, which shall consist of:

(A) premiums paid on behalf of covered persons;

(B) assessments and other revenues collected or received by the Board;

(C) reserves for future losses maintained by the Board; and

(D) interest earnings from investment of the federally eligible individuals account funds; and

(E) grants provided pursuant to the federal Trade Act of 2002; and

(3) such other accounts as may be appropriate.

m. Charge and collect assessments paid by insurers pursuant to Section 12 of this Act and recover any assessments for, on behalf of, or against those insurers.

(Source: P.A. 93-33, eff. 6-23-03; 93-34, eff. 6-23-03.)

(215 ILCS 105/5) (from Ch. 73, par. 1305)

Sec. 5. Plan administrator.

a. The board shall select a plan administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted under this Section based on criteria established by the board which shall include:

(1) The plan administrator's proven ability to handle other large group accident and health benefit plans.

(2) The efficiency and timeliness of the plan administrator's claim processing procedures.

(3) An estimate of total net cost for administering the plan, including any discounts or income the Plan could expect to receive or benefit from.

(4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost-efficient manner.

(5) The financial condition and stability of the plan administrator.

b. The plan administrator shall serve for a period of 5 years subject to removal for cause and subject to the terms, conditions and limitations of the contract between the board and the plan administrator. At least one year prior to the expiration of each 5 year period of service by the current plan administrator, the board shall begin to advertise for bids to serve as the plan administrator for the succeeding 5 year period. Selection of the plan administrator for the succeeding period shall be made at least 6 months prior

to the end of the current 5 year period.

c. The plan administrator shall perform such functions relating to the plan as may be assigned to it including:

(1) establishment of a premium billing procedure for collection of premiums from plan participants. Billings shall be made on a periodic basis as determined by the board;

(2) payment and processing of claims and various cost containment functions; and

(3) other functions to assure timely payment of benefits to participants under the plan, including:

(a) making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made, and

(b) evaluating the eligibility of each claim for payment under the plan.

The plan administrator shall be governed by the requirements of Part 919 of Title 50 of the Illinois Administrative Code, promulgated by the Department of Insurance, regarding the handling of claims under this Act.

d. The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be as determined by the board.

e. The plan administrator shall pay or be reimbursed for claims expenses from the premium payments received from or on behalf of plan participants. If the plan administrator's payments or reimbursements for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide additional funds to the plan administrator for payment or reimbursement of such claims expenses.

f. The plan administrator shall be paid as provided in the contract between the Board and the plan administrator.

(Source: P.A. 90-30, eff. 7-1-97; 90-567, eff. 1-23-98; 91-357, eff. 7-29-99.)

(215 ILCS 105/6) (from Ch. 73, par. 1306)

Sec. 6. Contents of plan. The plan shall include, but is not limited to, the following:

a. Schedules of premiums and benefits, limitations, exclusions, deductibles, coinsurance payments, and other policy terms and conditions established in accordance with appropriate actuarial principles and all the requirements of this Act.

b. Procedures for applicants and participants to submit grievances under Section 3 of this Act.

(Source: P.A. 87-560.)

(215 ILCS 105/7) (from Ch. 73, par. 1307)

Sec. 7. Eligibility.

a. Except as provided in subsection (e) of this Section or in Section 15 of this Act, any person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and who has been for a period of at least 180 days and continues to be a resident of this State shall be eligible for Plan coverage under this Section if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar individual health insurance coverage for health reasons by a health insurance issuer; or

(2) A refusal by a health insurance issuer to issue individual health insurance coverage except at a rate exceeding the applicable Plan rate for which the person is responsible.

A rejection or refusal by a group health plan or health insurance issuer offering only stop-loss or excess of loss insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection.

b. The board shall promulgate a list of medical or health conditions for which a person who is either a citizen of the United States or an alien lawfully admitted for permanent residence and a resident of this State would be eligible for Plan coverage without applying for health insurance coverage pursuant to subsection a. of this Section. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection a. of this Section. The list shall be effective on the first day of the operation of the Plan and may be amended from time to time as appropriate.

c. Family members of the same household who each are covered persons are eligible for optional family coverage under the Plan.

d. For persons qualifying for coverage in accordance with Section 7 of this Act, the board shall, if it determines that such appropriations as are made pursuant to Section 12 of this Act are insufficient to allow the board to accept all of the eligible persons which it projects will apply for enrollment under the Plan, limit or close enrollment to ensure that the Plan is not over-subscribed and that it has sufficient resources to meet its obligations to existing enrollees. The board shall not limit or close enrollment for federally eligible individuals.

e. A person shall not be eligible for coverage under the Plan if:

(1) He or she has or obtains other coverage under a group health plan or health insurance coverage substantially similar to or better than a Plan policy as an insured or covered dependent or would be eligible to have that coverage if he or she elected to obtain it. Persons otherwise eligible for Plan coverage may, however, solely for the purpose of having coverage for a pre-existing condition, maintain other coverage only while satisfying any pre-existing condition waiting period under a Plan policy or a subsequent replacement policy of a Plan policy.

(1.1) His or her prior coverage under a group health plan or health insurance coverage, provided or arranged by an employer of

more than 10 employees was discontinued for any reason without the entire group or plan being discontinued and not replaced, provided he or she remains an employee, or dependent thereof, of the same employer.

(2) He or she is a recipient of or is approved to receive medical assistance, except that a person may continue to receive medical assistance through the medical assistance no grant program, but only while satisfying the requirements for a preexisting condition under Section 8, subsection f. of this Act. Payment of premiums pursuant to this Act shall be allocable to the person's spenddown for purposes of the medical assistance no grant program, but that person shall not be eligible for any Plan benefits while that person remains eligible for medical assistance. If the person continues to receive or be approved to receive medical assistance through the medical assistance no grant program at or after the time that requirements for a preexisting condition are satisfied, the person shall not be eligible for coverage under the Plan. In that circumstance, coverage under the plan shall terminate as of the expiration of the preexisting condition limitation period. Under all other circumstances, coverage under the Plan shall automatically terminate as of the effective date of any medical assistance.

(3) Except as provided in Section 15, the person has previously participated in the Plan and voluntarily terminated Plan coverage, unless 12 months have elapsed since the person's latest voluntary termination of coverage.

(4) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the Plan shall be limited to benefits incurred under the Plan for the time period for which premiums had been paid and the covered person remained eligible for Plan coverage.

(5) The Plan (i) until 3 years after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $2,000,000 in benefits on behalf of the covered person or (ii) 3 years or more after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $1,500,000 in benefits on behalf of the covered person.

(6) The person is a resident of a public institution.

(7) The person's premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of such employee, of a government agency or health care provider or, except when a person's premium is paid by the U.S. Treasury Department pursuant to the federal Trade Act of 2002.

(8) The person has or later receives other benefits or funds from any settlement, judgement, or award resulting from any accident or injury, regardless of the date of the accident or injury, or any other circumstances creating a legal liability for damages due that person by a third party, whether the settlement, judgment, or award is in the form

of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or assets remaining from those sources in an amount in excess of $300,000.

(9) Within the 5 years prior to the date a person's Plan application is received by the Board, the person's coverage under any health care benefit program as defined in 18 U.S.C. 24, including any public or private plan or contract under which any medical benefit, item, or service is provided, was terminated as a result of any act or practice that constitutes fraud under State or federal law or as a result of an intentional misrepresentation of material fact; or if that person knowingly and willfully obtained or attempted to obtain, or fraudulently aided or attempted to aid any other person in obtaining, any coverage or benefits under the Plan to which that person was not entitled.

f. The board or the administrator shall require verification of residency and may require any additional information or documentation, or statements under oath, when necessary to determine residency upon initial application and for the entire term of the policy.

g. Coverage shall cease (i) on the date a person is no longer a resident of Illinois, (ii) on the date a person requests coverage to end, (iii) upon the death of the covered person, (iv) on the date State law requires cancellation of the policy, or (v) at the Plan's option, 30 days after the Plan makes any inquiry concerning a person's eligibility or place of residence to which the person does not reply.

h. Except under the conditions set forth in subsection g of this Section, the coverage of any person who ceases to meet the eligibility requirements of this Section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

(Source: P.A. 94-17, eff. 1-1-06; 94-737, eff. 5-3-06; 95-547, eff. 8-29-07.)

(215 ILCS 105/7.1)

Sec. 7.1. Premiums.

(a) The Board shall establish premium rates for coverage as provided in subsection (d) of this Section.

(b) Separate schedules of premium rates based on sex, age, geographical location, and benefit plan shall apply for individual risks.

(c) The Board may provide for separate premium rates for optional family coverage for the spouse or one or more dependents who reside together in any eligible individual's or eligible person's household. The rates for each spouse or dependent who qualifies to be covered under this optional family coverage shall be such percentage of the applicable individual Plan rate as the Board, in accordance with appropriate actuarial principles, shall establish.

(d) The Board, with the assistance of the Director and in accordance with appropriate actuarial principles, shall determine a standard risk rate by using

the average rates that individual standard risks in this State are charged by at least 5 of the largest health insurance issuers providing individual health insurance coverage to residents of Illinois that is substantially similar to the coverage offered by the Plan. In determining the average rate or charges of those health insurance issuers, the rates charged by those issuers shall be actuarially adjusted to determine the rate or charge that would have been charged for benefits similar to those provided by the Plan. The standard risk rates shall be established using reasonable actuarial techniques and shall reflect anticipated claims experience, expenses, and other appropriate risk factors for such coverage.

(e) Rates for Plan coverage shall not be less than 125% nor more than 150% of rates established as applicable for individual standard risks pursuant to subsection (d).

(Source: P.A. 90-30, eff. 7-1-97.)

(215 ILCS 105/8) (from Ch. 73, par. 1308)

Sec. 8. Minimum benefits.

a. Availability. The Plan shall offer in a periodically renewable policy major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the Plan shall pay an eligible person's covered expenses, subject to limit on the deductible and coinsurance payments authorized under paragraph (4) of subsection d of this Section, up to a lifetime benefit limit of $2,000,000 until 3 years after the effective date of this amendatory Act of the 95th General Assembly, and $1,500,000 in benefits 3 years or more after the effective date of this amendatory Act of the 95th General Assembly per covered individual. The maximum limit under this subsection shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board. Any person who otherwise would qualify for coverage under the Plan, but is excluded because he or she is eligible for Medicare, shall be eligible for any separate Medicare supplement policy or policies which the Board may offer.

b. Outline of benefits. Covered expenses shall be limited to the usual and customary charge, including negotiated fees, in the locality for the following services and articles when prescribed by a physician and determined by the Plan to be medically necessary for the following areas of services, subject to such separate deductibles, co-payments, exclusions, and other limitations on benefits as the Board shall establish and approve, and the other provisions of this Section:

(1) Hospital services, except that any services provided by a hospital that is located more than 75 miles outside the State of Illinois shall be covered only for a maximum of 45 days in any calendar year. With respect to covered expenses incurred during any calendar year ending on or after December 31, 1999, inpatient hospitalization of an eligible person for the treatment of mental illness at a hospital located within the State of Illinois shall be subject to the same terms and conditions

as for any other illness.

(2) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than dental and mental and nervous disorders as described in paragraph (17), which are rendered by a physician, or by other licensed professionals at the physician's direction. This includes reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

(2.5) Professional services provided by a physician to children under the age of 16 years for physical examinations and age appropriate immunizations ordered by a physician licensed to practice medicine in all its branches.

(3) (Blank).

(4) Outpatient prescription drugs that by law require a prescription written by a physician licensed to practice medicine in all its branches subject to such separate deductible, copayment, and other limitations or restrictions as the Board shall approve, including the use of a prescription drug card or any other program, or both.

(5) Skilled nursing services of a licensed skilled nursing facility for not more than 120 days during a policy year.

(6) Services of a home health agency in accord with a home health care plan, up to a maximum of 270 visits per year.

(7) Services of a licensed hospice for not more than 180 days during a policy year.

(8) Use of radium or other radioactive materials.

(9) Oxygen.

(10) Anesthetics.

(11) Orthoses and prostheses other than dental.

(12) Rental or purchase in accordance with Board policies or procedures of durable medical equipment, other than eyeglasses or hearing aids, for which there is no personal use in the absence of the condition for which it is prescribed.

(13) Diagnostic x-rays and laboratory tests.

(14) Oral surgery (i) for excision of partially or completely unerupted impacted teeth when not performed in connection with the routine extraction or repair of teeth; (ii) for excision of tumors or cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth; (iii) required for correction of cleft lip and palate and other craniofacial and maxillofacial birth defects; or (iv) for treatment of injuries to natural teeth or a fractured jaw due to an accident.

(15) Physical, speech, and functional occupational therapy as medically necessary and provided by appropriate licensed professionals.

(16) Emergency and other medically necessary

transportation provided by a licensed ambulance service to the nearest health care facility qualified to treat a covered illness, injury, or condition, subject to the provisions of the Emergency Medical Systems (EMS) Act.

(17) Outpatient services for diagnosis and treatment of mental and nervous disorders provided that a covered person shall be required to make a copayment not to exceed 50% and that the Plan's payment shall not exceed such amounts as are established by the Board.

(18) Human organ or tissue transplants specified by the Board that are performed at a hospital designated by the Board as a participating transplant center for that specific organ or tissue transplant.

(19) Naprapathic services, as appropriate, provided by a licensed naprapathic practitioner.

c. Exclusions. Covered expenses of the Plan shall not include the following:

(1) Any charge for treatment for cosmetic purposes other than for reconstructive surgery when the service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or surgery for the repair or treatment of a congenital bodily defect to restore normal bodily functions.

(2) Any charge for care that is primarily for rest, custodial, educational, or domiciliary purposes.

(3) Any charge for services in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(4) That part of any charge for room and board or for services rendered or articles prescribed by a physician, dentist, or other health care personnel that exceeds the reasonable and customary charge in the locality or for any services or supplies not medically necessary for the diagnosed injury or illness.

(5) Any charge for services or articles the provision of which is not within the scope of licensure of the institution or individual providing the services or articles.

(6) Any expense incurred prior to the effective date of coverage by the Plan for the person on whose behalf the expense is incurred.

(7) Dental care, dental surgery, dental treatment, any other dental procedure involving the teeth or periodontium, or any dental appliances, including crowns, bridges, implants, or partial or complete dentures, except as specifically provided in paragraph (14) of subsection b of this Section.

(8) Eyeglasses, contact lenses, hearing aids or their fitting.

(9) Illness or injury due to acts of war.

(10) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to a covered person

each policy year.

(11) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(12) Routine maternity charges for a pregnancy, except where added as optional coverage with payment of an additional premium for pregnancy resulting from conception occurring after the effective date of the optional coverage.

(13) (Blank).

(14) Any expense or charge for services, drugs, or supplies that are: (i) not provided in accord with generally accepted standards of current medical practice; (ii) for procedures, treatments, equipment, transplants, or implants, any of which are investigational, experimental, or for research purposes; (iii) investigative and not proven safe and effective; or (iv) for, or resulting from, a gender transformation operation.

(15) Any expense or charge for routine physical examinations or tests except as provided in item (2.5) of subsection b of this Section.

(16) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(17) Any expense incurred for benefits provided under the laws of the United States and this State, including Medicare, Medicaid, and other medical assistance, maternal and child health services and any other program that is administered or funded by the Department of Human Services, Department of Healthcare and Family Services, or Department of Public Health, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States.

(18) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy.

(19) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures.

(20) Any expense or charge for sterilization or sterilization reversals.

(21) Any expense or charge for weight loss programs, exercise equipment, or treatment of obesity, except when certified by a physician as morbid obesity (at least 2 times normal body weight).

(22) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery.

(23) Any expense or charge for or related to organ or tissue transplants other than those performed at a hospital with a Board approved organ transplant program that has been designated by the Board

as a preferred or exclusive provider organization for that specific organ or tissue transplant.

(24) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical speciality college for general use within the medical community.

d. Deductibles and coinsurance.

The Plan coverage defined in Section 6 shall provide for a choice of deductibles per individual as authorized by the Board. If 2 individual members of the same family household, who are both covered persons under the Plan, satisfy the same applicable deductibles, no other member of that family who is also a covered person under the Plan shall be required to meet any deductibles for the balance of that calendar year. The deductibles must be applied first to the authorized amount of covered expenses incurred by the covered person. A mandatory coinsurance requirement shall be imposed at the rate authorized by the Board in excess of the mandatory deductible, the coinsurance in the aggregate not to exceed such amounts as are authorized by the Board per annum. At its discretion the Board may, however, offer catastrophic coverages or other policies that provide for larger deductibles with or without coinsurance requirements. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

e. Scope of coverage.

(1) In approving any of the benefit plans to be offered by the Plan, the Board shall establish such benefit levels, deductibles, coinsurance factors, exclusions, and limitations as it may deem appropriate and that it believes to be generally reflective of and commensurate with health insurance coverage that is provided in the individual market in this State.

(2) The benefit plans approved by the Board may also provide for and employ various cost containment measures and other requirements including, but not limited to, preadmission certification, prior approval, second surgical opinions, concurrent utilization review programs, individual case management, preferred provider organizations, health maintenance organizations, and other cost effective arrangements for paying for covered expenses.

f. Preexisting conditions.

(1) Except for federally eligible individuals qualifying for Plan coverage under Section 15 of this Act or eligible persons who qualify for the waiver authorized in paragraph (3) of this subsection, plan coverage shall exclude charges or expenses incurred during the first 6 months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received during the 6 month period immediately preceding the effective

date of coverage.

(2) (Blank).

(3) Waiver: The preexisting condition exclusions as set forth in paragraph (1) of this subsection shall be waived to the extent to which the eligible person (a) has satisfied similar exclusions under any prior individual health insurance policy that was involuntarily terminated because of the insolvency of the issuer of the policy and (b) has applied for Plan coverage within 90 days following the involuntary termination of that individual health insurance coverage.

g. Other sources primary; nonduplication of benefits.

(1) The Plan shall be the last payor of benefits whenever any other benefit or source of third party payment is available. Subject to the provisions of subsection e of Section 7, benefits otherwise payable under Plan coverage shall be reduced by all amounts paid or payable by Medicare or any other government program or through any health insurance coverage or group health plan, whether by insurance, reimbursement, or otherwise, or through any third party liability, settlement, judgment, or award, regardless of the date of the settlement, judgment, or award, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the covered person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, and by all hospital or medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(2) The Plan shall have a cause of action against any covered person or any other person or entity for the recovery of any amount paid to the extent the amount was for treatment, services, or supplies not covered in this Section or in excess of benefits as set forth in this Section.

(3) Whenever benefits are due from the Plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered person has recovered or may recover damages from a third party or its insurer, the Plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable by the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.

During the pendency of any action or claim that is brought by or on behalf of a covered person against a third party or its insurer, any benefits that would otherwise be payable except for the provisions of this paragraph (3) shall be paid if payment by or for the third party has not yet been made and the covered person or, if incapable, that person's legal representative agrees in writing to pay back promptly the

benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness 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 the plan to repay benefits may be deducted from other benefits payable by the Plan after payments by or for the third party are made.

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

h. Right of subrogation; recoveries.

(1) Whenever the Plan has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence, or for which an insurer is liable in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for the damages, the Plan shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury. The Plan shall be subrogated to any right of recovery the covered person may have under the terms of any private or public health care coverage or liability coverage, including coverage under the Workers' Compensation Act or the Workers' Occupational Diseases Act, without the necessity of assignment of claim or other authorization to secure the right of recovery. To enforce its subrogation right, the Plan may (i) intervene or join in an action or proceeding brought by the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurer that may be liable or (ii) institute and prosecute legal proceedings against any third party or the third party's insurer that may be liable for the sickness or injury in an appropriate court either in the name of the Plan or in the name of the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors.

(2) If any action or claim is brought by or on behalf of a covered person against a third party or the third party's insurer, the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, shall notify the Plan by personal service or registered mail of the action or claim and of the name of the court in which the action or claim is brought, filing proof thereof in the action or claim. The Plan may, at any time thereafter, join in the action or claim upon its motion so that all orders of court after hearing and judgment shall be made for its protection. No release or settlement of a claim for damages and no satisfaction of judgment in the action shall be valid without the written consent of the Plan to the extent of its interest in

the settlement or judgment and of the covered person or his personal representative.

(3) In the event that the covered person or his personal representative fails to institute a proceeding against any appropriate third party before the fifth month before the action would be barred, the Plan may, in its own name or in the name of the covered person or personal representative, commence a proceeding against any appropriate third party for the recovery of damages on account of any sickness, injury, or death to the covered person. The covered person shall cooperate in doing what is reasonably necessary to assist the Plan in any recovery and shall not take any action that would prejudice the Plan's right to recovery. The Plan shall pay to the covered person or his personal representative all sums collected from any third party by judgment or otherwise in excess of amounts paid in benefits under the Plan and amounts paid or to be paid as costs, attorneys fees, and reasonable expenses incurred by the Plan in making the collection or enforcing the judgment.

(4) In the event that a covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, recovers damages from a third party for sickness or injury caused to the covered person, the covered person or the personal representative shall pay to the Plan from the damages recovered the amount of benefits paid or to be paid on behalf of the covered person.

(5) When the action or claim is brought by the covered person alone and the covered person incurs a personal liability to pay attorney's fees and costs of litigation, the Plan's claim for reimbursement of the benefits provided to the covered person shall be the full amount of benefits paid to or on behalf of the covered person under this Act less a pro rata share that represents the Plan's reasonable share of attorney's fees paid by the covered person and that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the expenditures to the full amount of the judgement, award, or settlement.

(6) In the event of judgment or award in a suit or claim against a third party or insurer, the court shall first order paid from any judgement or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees. After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the Plan the full amount of benefits paid on behalf of the covered person under this Act, provided the court may reduce and apportion the Plan's portion of the judgement proportionate to the recovery of the covered person. The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction. The court may consider the nature and extent of the injury, economic and non-economic loss, settlement

offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The Plan shall pay its pro rata share of the attorney fees based on the Plan's recovery as it compares to the total judgment. Any reimbursement rights of the Plan shall take priority over all other liens and charges existing under the laws of this State with the exception of any attorney liens filed under the Attorneys Lien Act.

(7) The Plan may compromise or settle and release any claim for benefits provided under this Act or waive any claims for benefits, in whole or in part, for the convenience of the Plan or if the Plan determines that collection would result in undue hardship upon the covered person.

(Source: P.A. 95-547, eff. 8-29-07; 96-791, eff. 9-25-09.)

(215 ILCS 105/8.5)

Sec. 8.5. (Repealed).

(Source: P.A. 89-514, eff. 7-17-96. Repealed by P.A. 91-639, eff. 8-20-99.)

(215 ILCS 105/8.6)

Sec. 8.6. Managed Care Reform and Patient Rights Act. The plan is subject to the provisions of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 105/8.7)

Sec. 8.7. Drug formulary; notice. The plan must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 92-440, eff. 8-17-01.)

(215 ILCS 105/9) (from Ch. 73, par. 1309)

Sec. 9. Taxation. The plan and the board established pursuant to this Act shall be exempt from payment of all fees and all taxes levied by the State or any of its subdivisions.

(Source: P.A. 85-702.)

(215 ILCS 105/10) (from Ch. 73, par. 1310)

Sec. 10. Collective action. Participation in the operation of the Plan, the establishment of rates, forms or procedures, or any other joint or collective action required by this Act shall not be the basis of any legal action, criminal or civil liability or penalty against the Plan, the plan administrator, the board or any of its members, employees, contractors, or consultants.

(Source: P.A. 90-30, eff. 7-1-97.)

(215 ILCS 105/11) (from Ch. 73, par. 1311)

Sec. 11. Plan notice. On and after the date the Illinois Comprehensive Health Insurance Plan becomes operational as provided in this Act, every insurer licensed to issue, and which issues for delivery, policies of accident and health insurance in this State shall include a notice of the existence of the Illinois Comprehensive Health Insurance Plan in any rejection of any application for individual health insurance coverage as defined in this Act for reasons of the health of the applicant or any other person proposed for insurance in such application. Such notice shall be in substantially the form and content prescribed by the Director.

(Source: P.A. 91-735, eff. 6-2-00.)

(215 ILCS 105/12) (from Ch. 73, par. 1312)

Sec. 12. Deficit or surplus.

a. If premiums or other receipts by the Board exceed the amount required for the operation of the Plan, including actual losses and administrative expenses of the Plan, the Board shall direct that the excess be held at interest, in a bank designated by the Board, or used to offset future losses or to reduce Plan premiums. In this subsection, the term "future losses" includes reserves for incurred but not reported claims.

b. Any deficit incurred or expected to be incurred on behalf of eligible persons who qualify for plan coverage under Section 7 of this Act shall be recouped by an appropriation made by the General Assembly.

c. For the purposes of this Section, a deficit shall be incurred when anticipated losses and incurred but not reported claims expenses exceed anticipated income from earned premiums net of administrative expenses.

d. Any deficit incurred or expected to be incurred on behalf of federally eligible individuals who qualify for Plan coverage under Section 15 of this Act shall be recouped by an assessment of all insurers made in accordance with the provisions of this Section. The Board shall within 90 days of the effective date of this amendatory Act of 1997 and within the first quarter of each fiscal year thereafter assess all insurers for the anticipated deficit in accordance with the provisions of this Section. The board may also make additional assessments no more than 4 times a year to fund unanticipated deficits, implementation expenses, and cash flow needs.

e. An insurer's assessment shall be determined by multiplying the total assessment, as determined in subsection d. of this Section, by a fraction, the numerator of which equals that insurer's direct Illinois premiums during the preceding calendar year and the denominator of which equals the total of all insurers' direct Illinois premiums. The Board may exempt those insurers whose share as determined under this subsection would be so minimal as to not exceed the estimated cost of levying the assessment.

f. The Board shall charge and collect from each insurer the amounts

determined to be due under this Section. The assessment shall be billed by Board invoice based upon the insurer's direct Illinois premium income as shown in its annual statement for the preceding calendar year as filed with the Director. The invoice shall be due upon receipt and must be paid no later than 30 days after receipt by the insurer.

g. When an insurer fails to pay the full amount of any assessment of $100 or more due under this Section there shall be added to the amount due as a penalty the greater of $50 or an amount equal to 5% of the deficiency for each month or part of a month that the deficiency remains unpaid.

h. Amounts collected under this Section shall be paid to the Board for deposit into the Plan Fund authorized by Section 3 of this Act.

i. An insurer may petition the Director for an abatement or deferment of all or part of an assessment imposed by the Board. The Director may abate or defer, in whole or in part, the assessment if, in the opinion of the Director, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection. The insurer receiving a deferment shall remain liable to the plan for the deficiency for 4 years.

j. The board shall establish procedures for appeal by any insurer subject to assessment pursuant to this Section. Such procedures shall require that:

(1) Any insurer that wishes to appeal all or any part of an assessment made pursuant to this Section shall first pay the amount of the assessment as set forth in the invoice provided by the board within the time provided in subsection f. of this Section. The board shall hold such payments in a separate interest-bearing account. The payments shall be accompanied by a statement in writing that the payment is made under appeal. The statement shall specify the grounds for the appeal. The insurer may be represented in its appeal by counsel or other representative of its choosing.

(2) Within 90 days following the payment of an assessment under appeal by any insurer, the board shall notify the insurer or representative designated by the insurer in writing of its determination with respect to the appeal and the basis or bases for that determination unless the Board notifies the insurer that a reasonable amount of additional time is required to resolve the issues raised by the appeal.

(3) The board shall refer to the Director any question concerning the amount of direct Illinois premium income as shown in an insurer's annual statement for the preceding calendar year on file with the Director on the invoice date of the assessment. Unless additional time is required to resolve the question, the Director shall within 60 days report to the board in writing his determination respecting the amount of direct Illinois premium income on file on the invoice date of the assessment.

(4) In the event the board determines that the insurer is entitled to a refund, the refund shall be paid within 30 days following the date upon which the board makes its determination, together with the accrued interest. Interest on any refund due an insurer shall be paid at the rate actually earned by the Board on the separate account.

(5) The amount of any such refund shall then be assessed against all insurers in a manner consistent with the basis for assessment as otherwise authorized by this Section.

(6) The board's determination with respect to any appeal received pursuant to this subsection shall be a final administrative decision as defined in Section 3-101 of the Code of Civil Procedure. The provisions of the Administrative Review Law shall apply to and govern all proceedings for the judicial review of final administrative decisions of the board.

(7) If an insurer fails to appeal an assessment in accordance with the provisions of this subsection, the insurer shall be deemed to have waived its right of appeal.

The provisions of this subsection apply to all assessments made in any calendar year ending on or after December 31, 1997.
(Source: P.A. 90-30, eff. 7-1-97; 90-567, eff. 1-23-98.)

(215 ILCS 105/13) (from Ch. 73, par. 1313)

Sec. 13. Civil actions; availability of remedies; costs; attorney fees.

(1) No civil action against the plan or board shall be allowed unless the party commencing the action has first filed a grievance and received a final decision thereon in accordance with the procedures established under paragraph (6) of subsection d of Section 3 of this Act. Any applicable time limitation for the filing of civil actions against the plan or the board shall commence upon the issuance of the board's final decision.

(2) In any action by or against the plan wherein there is in issue the liability of the plan on a policy or policies of insurance issued under this Act or the amount of the loss payable thereunder, or for an unreasonable delay in settling a claim, and it appears to the court that such action or delay is vexatious and unreasonable, the court may allow as part of the taxable costs in the action reasonable attorney fees, other costs, plus an amount not to exceed any one of the following amounts:

(a) 25% of the amount which the court or jury finds such party is entitled to recover against the plan, exclusive of all costs;

(b) $25,000;

(c) the excess of the amount which the court or jury finds such party is entitled to recover, exclusive of costs, over the amount, if any, which the plan offered to pay in settlement of the claim prior to the action.

(3) Where there are several policies insuring the same insured against the same loss whether issued by the same or by different companies, the court

may fix the amount of the allowance so that the total attorney fees on account of one loss shall not be increased by reason of the fact that the insured brings separate suits on such policies.
(Source: P.A. 87-560.)

(215 ILCS 105/14) (from Ch. 73, par. 1314)

Sec. 14. Confidentiality.

(a) All steps necessary under State and Federal law to protect confidentiality of applicants and covered persons shall be undertaken by the board to prevent the identification of individual records of persons covered under the Plan, rejected by the Plan, or who become ineligible for further participation in the Plan. Procedures shall be written by the board to assure the confidentiality of records of persons covered under, rejected by, or who become ineligible for further participation in, the Plan when gathering and submitting data to the board or any other entity.

(b) The information submitted to the board by hospitals pursuant to this Act shall be privileged and confidential, and shall not be disclosed in any manner. The foregoing includes, but shall not be limited to, disclosure, inspection or copying under The Freedom of Information Act, The State Records Act, and paragraph (1) of Section 404 of the Illinois Insurance Code. However, the prohibitions stated in this subsection shall not apply to the compilations of information assembled by the board pursuant to subsections c. and e. of Section 3 of this Act.
(Source: P.A. 90-30, eff. 7-1-97.)

(215 ILCS 105/14.05)

Sec. 14.05. Alternative portable coverage for federally eligible individuals.

(a) Notwithstanding the requirements of subsection a. of Section 7 and except as otherwise provided in this Section, any federally eligible individual for whom a Plan application, and such enclosures and supporting documentation as the Board may require, is received by the Board within 90 days after the termination of prior creditable coverage shall qualify to enroll in the Plan under the portability provisions of this Section.

A federally eligible person who has been certified as eligible pursuant to the federal Trade Act of 2002 and whose Plan application and enclosures and supporting documentation as the Board may require is received by the Board within 63 days after the termination of previous creditable coverage shall qualify to enroll in the Plan under the portability provisions of this Section.

(b) Any federally eligible individual seeking Plan coverage under this Section must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the Board's satisfaction, that he or she meets all of the requirements to be a federally eligible individual and is currently and permanently residing in this State (as of the date his or her application was

received by the Board).

(c) Except as otherwise provided in this Section, a period of creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 90 day period during all of which the individual was not covered under any creditable coverage.

For a federally eligible person who has been certified as eligible pursuant to the federal Trade Act of 2002, a period of creditable coverage shall not be counted, with respect to qualifying an applicant for Plan coverage as a federally eligible individual under this Section, if after such period and before the application for Plan coverage was received by the Board, there was at least a 63 day period during all of which the individual was not covered under any creditable coverage.

(d) Any federally eligible individual who the Board determines qualifies for Plan coverage under this Section shall be offered his or her choice of enrolling in one of alternative portability health benefit plans which the Board is authorized under this Section to establish for these federally eligible individuals and their dependents.

(e) The Board shall offer a choice of health care coverages consistent with major medical coverage under the alternative health benefit plans authorized by this Section to every federally eligible individual. The coverages to be offered under the plans, the schedule of benefits, deductibles, co-payments, exclusions, and other limitations shall be approved by the Board. One optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this State or a standard option of coverage available under the group or individual health insurance laws of the State. The standard benefit plan that is authorized by Section 8 of this Act may be used for this purpose. The Board may also offer a preferred provider option and such other options as the Board determines may be appropriate for these federally eligible individuals who qualify for Plan coverage pursuant to this Section.

(f) Notwithstanding the requirements of subsection f. of Section 8, any plan coverage that is issued to federally eligible individuals who qualify for the Plan pursuant to the portability provisions of this Section shall not be subject to any preexisting conditions exclusion, waiting period, or other similar limitation on coverage.

(g) Federally eligible individuals who qualify and enroll in the Plan pursuant to this Section shall be required to pay such premium rates as the Board shall establish and approve in accordance with the requirements of Section 7.1 of this Act.

(h) A federally eligible individual who qualifies and enrolls in the Plan pursuant to this Section must satisfy on an ongoing basis all of the other eligibility requirements of this Act to the extent not inconsistent with the federal Health Insurance Portability and Accountability Act of 1996 in order to maintain continued eligibility for coverage under the Plan.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 105/15)

Sec. 15. This Act takes effect July 1, 1987.

(Source: P.A. 95-331, eff. 8-21-07.)

ILLINOIS RESPONSE TO HHS TEMPORARY HIGH RISK POOL SOLICITATION

APPENDIX C:

Illinois CHIP Grievance Procedure

Illinois Comprehensive Health Insurance Plan

Pat Quinn, Governor
Michael T. McRaith, Chairman of the Board of Directors
Timothy C. Sullivan, Executive Director

ILLINOIS COMPREHENSIVE HEALTH INSURANCE PLAN GRIEVANCE PROCEDURES

As an applicant or claimant, if you receive and are dissatisfied with an adverse decision involving your application or eligibility for CHIP coverage, or any claim you have submitted to the Administrator, you have the right to appeal that adverse decision pursuant to the following Grievance Procedures which have been adopted by the CHIP Board of Directors and are also outlined in Part S of all CHIP Benefit Plan Booklets.

If you feel a decision made by the Administrator or Board staff is wrong, you have the right to appeal the decision by following these steps:

Step 1. You have 60 days from the date you are notified of any adverse action involving enrollment, eligibility or a claim in which to send a written complaint to CHIP, our Plan Administrator, Blue Cross and Blue Shield of Illinois, or, if the grievance is concerning a prescription claim, our Prescription Administrator, Walgreens Health Initiatives. The complaint shall be reviewed by a supervisor in the unit from which the complaint arose.

Step 2. If the results of this review are not satisfactory to you, you have 30 days to send a written complaint to the Plan Administrator, Blue Cross and Blue Shield of Illinois, Attention: ICHIP Administrative Officer, P.O. Box 2401, Chicago, IL 60690, and obtain a second review of the complaint by the department head of the Administrator. For prescriptions only, send a written complaint to the Prescription Administrator, Walgreens Health Initiatives, P. O. Box 269, Deerfield, IL 60015.

Step 3. If you are dissatisfied with the decision made by the department head of the Administrator on your second level appeal, you have 30 days in which to send a written complaint to the Grievance Committee of the Board, 320 West Washington Street, Suite 700, Springfield, Illinois 62701-1150. You must complete the first and second steps in accordance with these Grievance Procedures, and you must have received written decisions concerning your first and second level appeals with which you remain dissatisfied, before proceeding with step three involving the Board's Grievance Committee.

The decision of the Grievance Committee of the Board will be sent to you in writing and will be the final action of the Illinois Comprehensive Health Insurance Plan.

EXPLORE THE CHIP WEBSITE

Tel 217-782-6333 | Toll Free (Illinois only) 866-851-2751 | (TTY) 800-545-2455

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ILLINOIS RESPONSE TO HHS TEMPORARY HIGH RISK POOL SOLICITATION

APPENDIX D:

Performance Standards

ARTICLE XIII
PERFORMANCE STANDARDS

Section 1. Administrator agrees to adhere to the following minimum performance standards as specified in this Article XIII of this Agreement beginning January 1, 2002 for each month of this Agreement:

A. Claim Turnaround Time: The Administrator shall process: 1) 90% of all clean claims within fourteen (14) calendar days of receipt; 2) 99.5% of all clean claims within thirty (30) calendar days of receipt; 3) 80% of all investigated claims within twenty-one (21) calendar days of receipt by the Administrator of additional information from an outside source; and 4) 99.5% of all investigated claims within sixty (60) calendar days of receipt by the Administrator of additional information from an outside source. For purposes of this standard, "clean claims" shall mean claims which do not require additional information from a source outside the Administrator, and "investigated claims" shall mean claims which require additional information from a source outside the Administrator. A claim shall be considered "processed" for purposes of the standard whenever it is paid (including application towards the deductible), denied or the Administrator has requested additional information from an outside source that is adequate to resolve the claim.

B. Financial Accuracy of Claim Payments: The Administrator shall maintain, at a minimum, an average accuracy ratio of 98%. The accuracy ratio is calculated as follows:

$$\frac{\text{(total charges handled in sample - charges handled in error)}}{\text{total charges handled in sample}}$$

where sample size must, at a minimum, be sufficient to provide a 95% confidence level with no more than a 5% error level of all claims processed per processor per day pulled for quality review. "Charges handled in error" are to be based on the absolute value of all errors (i.e., overpayments are not to be offset or netted against underpayment errors).

C. Procedural Accuracy of Claim Payments: The Administrator shall maintain at a minimum an average procedural accuracy ratio of 98%. The procedural accuracy ratio is calculated as follows:

$$\frac{\text{(number of claims reviewed – number of procedural errors)}}{\text{number of claims reviewed}}$$

where sample size must, at a minimum, be sufficient to provide a 95% confidence level with no more than a 5% error level for all claims processed per processor per day pulled for quality review.

D. Telephone (including TDD/TTY) Inquiry Accessibility and Response: The Administrator shall answer 85% of all toll-free telephone calls to dedicated lines for the Plan Customer Service number(s) maintained by the Administrator within 30 seconds. This standard shall be applied during the Administrator's normal business hours. For purposes of this standard,

"answered" shall mean picked up by a human Customer Service Representative, except for requests for forms or informational kits, which may be handled by an automated attendant.

E. Complaint Response Turnaround: The Administrator shall:

1. Issue a response to 90% of all complaints within fourteen (14) days of receipt. This does not include any complaints which are submitted in accordance with the Board's grievance procedures or any complaints which are received from attorneys on behalf of Participants for which the standards in Paragraphs 2 and 3 below apply. The remaining 10% shall be processed within thirty (30) days of receipt. Subsequent complaints on the same problem shall be considered Step 1 Grievances and handled as described below;

2. Respond to or refer to the Board Office all complaints which are considered to be part of the Board's grievance procedures within the following timer period: 1) Step 1 level grievances shall be responded to by the Administrator within 30 days of receipt by the Administrator; b) Step 2 level grievances shall be responded to by the Administrator within 60 days of receipt by the Administrator; and c) all Step 3 level grievances shall be referred to the Board Office within 5 days of receipt by the Administrator; and

3. Refer to the Board Office within 3 days of receipt and respond within the specified timeline specified in Paragraph 1 or 2 above, based upon the classification of the complaint received, all complaints or other correspondence which the Administrator receives from attorneys on behalf of any current or former Participant.

For purposes of this standard, "complaint" shall mean any written communication primarily expressing dissatisfaction from a Participant or their legal representative. "Response" shall mean a written response from the Administrator expressing all actions, taken or not taken, and which were the basis for the complaint.

F. Issuance of Enrollment Materials: For health plans administered by the Administrator, the Administrator shall issue 99% of all required enrollment or fulfillment materials (Benefit Plan booklet, schedule page and participant identification card) within no later than ten (10) working days after the Administrator receives notification by the Board Office that an application for coverage of a new Participant has been finally approved and to enroll that individual(s), or within ten (10) working days of an applicant's effective date of coverage, whichever is later.

G. Report Production & Transmittal: The Administrator shall provide the Board with all of the reports required by Article VIII of this Agreement within fifteen calendar days after the end of the reporting period, except those reports required on a weekly basis which shall be provided within seven calendar days of the end of the reporting period, and except those reports for which a

different time period is specifically provided for in Article VIII which shall then be provided within the time specified therein.

Section 2. Performance Penalties. Adherence to the performance standards specified in Section 1 of this Part XIII shall be measured and reported to the Board each month based upon a monthly audit by the Administrator of its performance under each standard. The audit methodology of performance standards shall be developed by the Administrator and approved by the Board. The Administrator shall report and submit supporting documentation satisfactory to the Board to substantiate the results of each prior month's performance results audit to the Board or its designee together with its monthly fee statement. The Administrator agrees that the Board or its designee may conduct an independent audit at Board expense of the items audited by the Administrator using the same standards referenced herein. If there is any discrepancy between the performance measured by the Board's audit and the Administrator's audit, that discrepancy shall be resolved by the Board of Directors of the Plan.

A financial penalty of a 5% reduction in the Administrator's monthly fee as determined under Article XII hereof shall be assessed for each performance standard to which the Administrator fails to adhere, for each month that standard was not adhered to. The Board will give consideration to requests for waiving this financial penalty, should extraordinary circumstances exist for the Administrator as a result of action taken or approved by the Board.

ILLINOIS RESPONSE TO HHS TEMPORARY HIGH RISK POOL SOLICITATION

APPENDIX E:

Actuarial Attestation

Hause Actuarial Solutions, Inc.
7201 W. 129th St., Suite 310
Overland Park, KS 66213

May 27, 2010

Mr. Timothy Sullivan
Executive Director
Illinois Comprehensive Health Insurance Plan
320 West Washington Street, Suite 700
Springfield, IL 62701-1150

ACTUARIAL ATTESTATION FOR FEDERAL QUALIFIED HIGH RISK POOL

Dear Tim:

The purpose of this letter is to provide an actuarial attestation regarding Illinois' response to the Federal Qualified High Risk Pool Request for Proposal, with regard to question C.4.2 (5).

The Illinois Qualified High Risk Pool PPO plan is a $2,000 deductible, 20% coinsurance of the next $11,750 of covered expenses with a total medical out-of-pocket limit of $4,350 and the prescription drug benefit has copays but with a total drug benefit out-of-pocket limit of $1,600.

The Pool's expected average share of the total allowed costs of the required benefits is over 65% of such costs.

The out-of-pocket limit of coverage for cost sharing is equal to the applicable amount described in section 223(c)(2) of the Internal Revenue Code which for 2010 and 2011 is $5,950.

I, John K. Ahrens, am an actuarial consultant of Hause Actuarial Solutions, Inc. I am a member of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Sincerely,

John K. Ahrens, FSA, MAAA
Consulting Actuary

Phone: (913)685-2200 • Fax: (913)685-2205
Website: www.hauseactuarial.com • E-Mail: johna@hauseactuarial.com

ILLINOIS RESPONSE TO HHS TEMPORARY HIGH RISK POOL SOLICITATION

APPENDIX F:

C.5 Actuarial Attestation

Hause Actuarial Solutions, Inc.
7201 W. 129th St., Suite 310
Overland Park, KS 66213

May 27, 2010

Mr. Timothy Sullivan
Executive Director
Illinois Comprehensive Health Insurance Plan
320 West Washington Street, Suite 700
Springfield, IL 62701-1150

ACTUARIAL ATTESTATION FOR FEDERAL QHRP – TABLE 2

The purpose of this letter is to provide an actuarial attestation regarding Illinois' response to the Federal Qualified High Risk Pool Request for Proposal, with regard to question C.5 Table 2. The Illinois Qualified High Risk Pool will offer only one option, a PPO plan with a $2,000 deductible, 20% coinsurance of the next $11,750 of covered expenses with a total medical out-of-pocket limit of $4,350 and the prescription drug benefit has copays but with a total drug benefit out-of-pocket limit of $1,600.

Hause has estimated the expected enrollment, premium, claims and expenses and subsidy to be covered from the Federal allocation beginning July 1, 2010 and ending December 31, 2013. The projections were made on an accrual basis so no claims or expenses are shown for 2014 even though claims run out is expected.

It is very likely that demand for the QHRP will exceed the Federal allocation, so the Pool will be closely monitored to maximize enrollment and use of the Federal allocation without exceeding the expected $196,000,000. Actual results for all of the assumptions may be significantly different than projected due to the unique nature of the program. We have made reasonable assumptions and the calculations are actuarially sound based on those assumptions, however new calculations will be required on a frequent basis to reach the goal of maximizing the allocation without exceeding the amount.

I, John K. Ahrens, am an actuarial consultant of Hause Actuarial Solutions, Inc. I am a member of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Sincerely,

John K. Ahrens, FSA, MAAA
Consulting Actuary

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