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.
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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 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: $1,300, $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: $1,300, $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 $5 million in lifetime maximum benefits under CHIP;

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; 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;

6. 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

7. 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)  Arteriosclerosis Obliterans
Angina Pectoris Chemical Dependency
Cerebrovascular Accident (Stroke)  Coronary Insufficiency
Cirrhosis of the Liver Cystic Fibrosis
Coronary Occlusion Hemophilia (Classical)
Friedreich's Ataxia Huntington's Chorea
Hodgkin's Disease Kidney Failure Requiring Dialysis
Juvenile Diabetes Lupus Erythematosus Disseminate
Leukemia Multiple or Disseminated Sclerosis
Metastatic Cancer Myasthenia Gravis
Muscular Atrophy or Dystrophy Paraplegia or Quadriplegia
Myotonia Poliomyelitis
Parkinson's Disease Polycystic Kidney
Severe Traumatic Brain Injury Sickle Cell Anemia
Silicosis Pneumoconiosis (Black Lung) Syringomyelia
Wilson's Disease
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 (see below for a description of 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 enrolled in Medicare Part A or 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; TRICARE/CHAMPUS, or other health benefit
plans for the uniformed services of the United States;
5. A medical care program of the Indian Health Service or of tribal organizations;
6. A state health benefits risk pool (such as CHIP);
7. The Federal Employees Health Benefits Program (FEHBP);
8. A public health plan established by a state, county, or other political subdivision of a state that provides health insurance coverage; or

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 ELIGIBLE?

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. Applications for minor children of divorced parents must be submitted by the residential custodial parent with a copy of the custody agreement. 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)
(855) 691-7156 (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 1-855 691-7156 (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 (855) 691-7156 (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:

   Catamaran
   Toll-free Number 877-629-3121 (Member Services)
   855-427-4682 (Specialty Pharmacy) -866-830-4366 (TTY)
   866-889-0585 (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 $5 million for all sicknesses and injuries combined.

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, tobacco usage, 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

CHIP premiums are due monthly. You can choose between receiving an invoice monthly or having your premium deducted automatically from your bank account through a bank draft arrangement. 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.

The initial premium payment must be tendered by certified check, cashier’s check or money order. You must 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 invoiced or automatically deducted from your account. For HCTC participants (the HIPAA-HCTC Plans) the monthly invoice option is the only option available if you wish to use the advance tax credit available to HCTC participants, since these premium payments are coordinated with the HCTC. Refer to the rate table for more information about how the advance tax credit works.
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, tobacco usage, deductible, 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/NON DUPLICATION 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 United 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:

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Reimbursement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO Provider</td>
<td>80% of covered charges</td>
</tr>
<tr>
<td>Non-PPO Provider</td>
<td>60% of covered charges</td>
</tr>
</tbody>
</table>

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](http://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.mycatamaranRx.com](http://www.mycatamaranRx.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 the due date, 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: $1,300, $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, $1,300, $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%.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Covered Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Medicare Plan</td>
<td>80% (Medicare is primary)</td>
</tr>
<tr>
<td>All Other Plans (the PPO Plans)</td>
<td>80%; 60% if non-PPO providers are used</td>
</tr>
</tbody>
</table>
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 30 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 $5 million.

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 $5 million.

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

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