

**PRE-EXISTING CONDITION INSURANCE PLAN  
("PCIP")**

**COMPREHENSIVE MAJOR MEDICAL  
EXPENSE POLICY**

**Administered By:  
The Arkansas Comprehensive Health Insurance Pool ("CHIP") and its subcontractor,  
BlueAdvantage Administrators**

**OUTLINE OF COVERAGE  
Relating to Policy Form PCIP 101 (7/10)**

This Outline of Coverage is not a policy. The complete terms of the PCIP coverage are set forth in the PCIP insurance policy identified in the heading above ("Policy"). This Outline of Coverage provides a brief description of important features of the Policy offered by PCIP to Arkansas residents. The Policy itself sets forth in detail the rights and obligations of Insured Persons and the PCIP program under the Policy.

This Policy provides **Major Medical Expense Coverage**. Policies of this category are designed to provide coverage to Insured Persons for major hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care and prescription drugs, subject to any Deductibles, Coinsurance or Copayment provisions, or other limitations and exclusions set forth in the Policy. **Inpatient admissions require pre-certification from the Administrator. Failure to pre-certify admissions results in a reduction in benefits. (See page 5 of this Outline of Coverage.)**

**DEFINITIONS**

Key terms used in the Eligibility Worksheet, Enrollment Forms and this Outline of Coverage are defined below. The Policy contains additional definitions of medical and insurance terms used in the Policy.

**Administrator** means BlueAdvantage Administrators, acting as subcontractor for CHIP.

**Annual Coinsurance Limit** means a dollar amount limit paid by Insured Persons for certain Covered Expenses. After the Annual Coinsurance Limit is reached, PCIP pays most In-Network benefits at 100% for the remainder of the year. (See pages 4-5 of this Outline of Coverage.)

**Coinsurance** means the percentage of Covered Expenses for which an Insured Person is responsible according to the Schedule of Benefits in his or her Policy and applies after the Insured Person satisfies his or her Deductible requirement.

**Copayment** means a dollar amount that the Insured Person owes each time he or she uses particular types of services, such as obtaining an annual physical examination or purchasing prescription drugs. Copayments are not subject to the Deductible

**Covered Expense** means an expense that PCIP has agreed to pay under the Policy if medically necessary and not otherwise limited or excluded by the terms, conditions, and limitations of the Policy. Please see the Policy for more information.

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

- Health Insurance Coverage (including individual coverage, job-based coverage, COBRA and conversion coverage);
- Medicare (Part A or Part B);
- A Medical Assistance Program (Medicaid, including ARKids First-A);
- Title XXI of the Social Security Act (the State Children's Health Insurance Program, which includes children covered under ARKids First-B in Arkansas);
- A state health benefits risk pool, such as state plans offered through CHIP;
- Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the armed forces and the commissioned personnel of certain other agencies);
- A public health plan established by the United States, any state or a foreign country, or a political subdivision of the United States, any state or a foreign country, that provides health coverage to individuals enrolled in the plan;
- A health plan offered under Chapter 89 of Title 5, United States Code (the plan covering most federal employees);
- A medical care program of the Indian Health Service or of a tribal organization;
- A health benefit plan under § 5 (e) of the Peace Corps Act, 22 U.S.C. § 2504(e);

Benefits Excluded From Definition of Creditable Coverage. Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits, (as described in 45 C.F.R. § 146.145). Such excepted benefits, include, but may not be limited to:

- Accident only (including accidental death and dismemberment), disability income, general liability, automobile liability, coverage that is supplemental to liability insurance, automobile medical coverage, workers' compensation or similar coverage,

credit-only insurance such as mortgage insurance and coverage for on-site medical clinics.

- Limited-scope benefits such as dental, vision and long-term care, if provided under a separate policy or contract than a group health plan, or otherwise are not an integral part of the health plan, because the individual can elect not to receive the additional limited-scope benefits and, if the individual does elect to receive the benefits, he or she must pay additional premium.

**Deductible** means the calendar year Deductible amount set forth in an Insured Person's Coverage Summary and PCIP I.D. card, which is the amount of Covered Expenses the Insured Person must pay each year from his or her own pocket before PCIP will make payment for Covered Expenses. Copayments are not subject to the annual Deductible.

**Health Insurance or Health Insurance Coverage** means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, hospital or medical service corporation, health maintenance organization, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise and includes any excess or stop-loss coverage.

Excluded from definition: Health Insurance *does not* include any types of coverage excluded from the definition of Creditable Coverage, or short-term limited duration policies.

**Included Covered Expense** is a Covered Expense that counts toward the Annual Coinsurance Limit and is paid at 100% for the remainder of a calendar year once an Insured Person reaches the Annual Coinsurance Limit.

**In-Network Providers** mean hospitals, physicians, or other providers who are paid directly by the Administrator and have agreed to accept the PCIP payment for Covered Expenses as payment in full except for any applicable Deductible and Coinsurance.

**Insured Person** is a person whose application is accepted by the Administrator and in whose name this Policy is issued and who continues to meet the eligibility requirements included in the Policy.

**Out-of-Network Providers** are all providers that are not In-Network Providers.

## WHO IS COVERED BY THIS POLICY?

**To be eligible for PCIP coverage in Arkansas you must:**

1. Be a resident of Arkansas;

2. Be a citizen or national of the United States or an alien lawfully present in the United States;
3. Have not been covered under Creditable Coverage at any point during the 6-month period prior to the date of this Application; and
4. During the past 6 months, have been:
  - a. Declined individual health coverage in Arkansas; or
  - b. Offered individual health coverage in Arkansas with a rider excluding a pre-existing medical condition(s).

**HOW MUCH ARE PREMIUM PAYMENTS?**

Premiums vary based on age and whether or not an Insured Person has used tobacco products within the last 12 months. The following chart reflects current monthly premium rates:

<b>\$1,000 Deductible Plan Rates</b>		
Age Group	Tobacco User	Non-Tobacco User
<30	\$201.80	\$156.08
30-34	\$241.94	\$187.12
35-39	\$286.69	\$221.73
40-44	\$336.99	\$260.64
45-49	\$410.64	\$317.60
50-54	\$510.12	\$394.54
55-59	\$651.39	\$503.80
60-64	\$807.20	\$624.32

An Insured Person may pay premiums on a monthly or quarterly basis. The first premium is due with the application for coverage.

**GENERAL DESCRIPTION OF BENEFITS**

**Annual Deductible and Coinsurance Limit**

The annual Deductible for PCIP is \$1,000 per calendar year. For many Covered Expenses, an Insured Person will need to pay his or her annual deductible first before receiving PCIP benefit payments. However, any benefit subject to a Copayment is not subject to the Annual Deductible.

The Annual Coinsurance Limit applies only to Included Covered Expenses. Generally, Included Covered Expenses are most Covered Expenses for services performed by In-Network Providers.

They do not include services subject to a Copayment or any services by Out-of-Network Providers. The Annual Coinsurance Limit is the most an Insured Person will pay for Included Covered Expenses out of his or her own pocket per calendar year. Current Annual Deductible and Coinsurance Limits for PCIP plans (per calendar year) are as follows:

<u>Deductible</u>	<u>Annual Coinsurance Limit</u>
\$1,000	\$2,000

**IMPORTANT NOTICE: Covered Expenses provided by an Out-of-Network Provider DO NOT COUNT towards the Annual Coinsurance Limit. However, an Insured Person will receive a higher level of benefits for most out-of-network care once he or she reaches the Annual Coinsurance Limit. Please see the Policy for more information.**

### **Covered Services and Pre-Certification**

Services covered under the Policy include the following, subject to limitations and exclusions included in the Policy:

- In patient hospital care, including standard private room and intensive/coronary care unit
- Miscellaneous hospital Services
- Skilled nursing facility care
- Diagnostic X-ray and laboratory
- Outpatient care
- Surgical services
- Anesthesia services
- Office visits to physicians and other qualified providers
- Wellness care, including annual physical, vaccinations, routine mammography, prostate screenings, pap smears (In-Network providers only)
- Durable medical equipment, supplies and appliances
- Prescription drugs
- Home health care and hospice care
- Diabetes self-management training
- Maternity care

**IMPORTANT:** All inpatient admissions (into a hospital or other facility) require pre-certification. To pre-certify benefits, the hospital, provider or Insured Person contacts the Administrator, usually by phone. The Administrator evaluates the medical necessity and appropriateness of the procedure, service, supply, drug, or article and provides written verification, or Pre-certification, to both the hospital or provider and the Insured Person.

**FAILURE TO PRE-CERTIFY MAY RESULT IN A \$500 REDUCTION IN BENEFITS.**

### **In-Network versus Out-of-Network Providers.**

PCIP coverage is most effective and advantageous when the Insured Person utilizes the services of In-Network Providers. Reimbursement for services by Out-of-Network Providers generally

will be less than payment for the same services when provided by In-Network Providers and could result in substantial additional out-of-pocket expense.

In-Network Providers are paid directly by the Administrator and have agreed to accept the PCIP payment for Covered Expenses as payment in full except for any applicable Deductible and Co-Insurance. On the other hand, when the Insured Person receives services from Out-of-Network Providers, the Insured Person is responsible for all balances when services are rendered and must file a claim with the Administrator to be reimbursed for PCIP's share of the Covered Expenses. The determination of whether a hospital, physician, or other provider is an In-Network Provider or an Out-of-Network Provider is the responsibility of the Administrator. The Administrator can provide a list of In-Network Providers.

The decision about whether to use an In-Network Provider is the sole responsibility of the Insured Person. In-Network Providers are not employees or agents of the PCIP program or the Administrator. Neither the PCIP program nor the Administrator makes any representations or guarantees regarding the qualification or experience of any facility or provider with respect to any service. The evaluation of such factors and the decision about whether to use any facility or provider is the sole responsibility of the Insured Person.

### **Prescription Drugs**

Covered Expenses include insulin and other prescription drugs requiring a Physician's order that relate directly to the treatment of an Illness or Injury. This Policy does not cover prescription drugs for the purpose of contraception, to treat fertility or for weight loss. The Policy also does not cover compound drugs or drugs, devices or supplies obtained through out-of-the-country mail order pharmacies. The Insured Person pays a Copayment for prescription drugs of \$10, \$30 or \$70, depending on whether the drug is generic, preferred or non-preferred. Each Insured Person receives a prescription drug card which will allow purchase of prescription drugs from the Insured Person's pharmacist.

### **Maximum Lifetime Benefit**

Maximum lifetime benefits under PCIP shall not exceed \$1,000,000 per Insured Person.

### **Limitations**

Limitations under the Policy include, but are not limited to, the following. (See the Policy for a full discussion of its limitations.)

- Expenses for diagnosis and treatment of chemical or drug dependency, and for drugs prescribed to treat chemical or drug dependency, are limited to maximum annual Covered Expenses of \$4,000, and have other limitations. Please check the Policy for more information on this benefit.

- Expenses for diagnosis and treatment of mental or nervous disorders are limited to maximum annual Covered Expenses of \$4,000, and have other limitations. Please check the Policy for more information on this benefit.
- Home health care is covered up to 270 visits per calendar year by a registered nurse or licensed practical nurse.
- Diabetes self-management training is limited to one lifetime benefit as prescribed by a physician.
- Care in a skilled nursing facility is covered up to one hundred twenty (120) days per calendar year, certified sixty (60) days at a time.

### **Exclusions**

A full list of exclusions is included in the Policy. Services excluded from the policy include, but are not limited to, treatment that is not medically necessary, routine eye exams and eye exercises, foot care, private duty nursing services for hospital inpatients, obesity or weight control programs or surgery, acupuncture, massage therapy, birth control and infertility treatments, treatment for sexual dysfunction, cosmetic surgery and self-inflicted wounds.

## **CLAIMS**

### **Filing a Claim**

In most cases, the Insured Person does not have to file a claim for Covered Expenses, because most Hospitals and Providers will bill us directly, or because the Insured Person simply pays a Copayment, such as when obtaining prescription drug benefits from a pharmacy. However, the Insured Person will have to send us the itemized bill when an Out-of-Network Physician, Hospital or other Provider bills him or her directly, whether the Provider is located inside or outside of Arkansas.

### **Time Limitation in Which to File a Claim**

The Insured Person must submit written proof of any services, supplies, drugs, or articles or treatment and the charges to the Administrator not later than six (6) months from the date such services, supplies, drugs, or articles or treatment were received. The failure to file a claim for a Covered Expense within this deadline will cause such Covered Expense to be excluded from coverage under this Policy. Since PCIP will cease coverage on December 31, 2013, claims incurred by December 31, 2013 must be submitted by the close-out period of June 30, 2014.