

[215 Ill. Comp. Stat. §§ 105/1 through 105/8.]

§§ 105/1 through 105/8: Comprehensive Health Insurance Plan Act

§ 1. Short title.

This Act shall be known and may be cited as the Comprehensive Health Insurance Plan Act.

§ 1.1. Legislative findings and declarations.

The General Assembly hereby makes the following findings and declarations:

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

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

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

§ 2. Definitions.

As used in this Act, unless the context otherwise requires:

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

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

"Board" means the Illinois Comprehensive Health Insurance Board.

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

"Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or State law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2, 367e, and 367e.1 of the Illinois Insurance Code, or any other similar requirement in another State.

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

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

- (A) A group health plan.
- (B) Health insurance coverage (including group health insurance coverage).
- (C) Medicare.
- (D) Medical assistance.
- (E) Chapter 55 of title 10, United States Code.
- (F) A medical care program of the Indian Health Service or of a tribal organization.
- (G) A state health benefits risk pool.
- (H) A health plan offered under Chapter 89 of title 5, United States Code.
- (I) A public health plan (as defined in regulations consistent with Section 104 of the Health Care Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the U.S. Department of Health and Human Services).
- (J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- (K) Any other qualifying coverage required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or regulations under that Act.

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 2791(c) of title XXVII of the Public Health Service Act (42 U.S.C. 300 gg-91), nor does it include any period of coverage under any of items (A) through (K) that occurred before a break of more than 90 days or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, a break of more than 63 days during all of which the individual was not covered under any of items (A) through (K) above.

Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period under the terms of health insurance coverage offered

by a health maintenance organization shall not be taken into account in determining if there has been a break of more than 90 days in any creditable coverage.

"Department" means the Illinois Department of Insurance.

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

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

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

"Effective date of medical assistance" means the date that eligibility for medical assistance for a person is approved by the Department of Human Services or the Department of Healthcare and Family Services, except when the Department of Human Services or the Department of Healthcare and Family Services determines eligibility retroactively. In such circumstances, the effective date of the medical assistance is the date the Department of Human Services or the Department of Healthcare and Family Services determines the person to be eligible for medical assistance. As it pertains to Medicare, the effective date is 24 months after the entitlement date as approved by the Social Security Administration, except when eligibility is made retroactive to a prior date. In such circumstances, the effective date of Medicare is the date on the Notice of Award letter issued by the Social Security Administration.

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

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

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

"Family" coverage means the coverage provided by the Plan for the covered person and his or her eligible dependents who also are covered persons.

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

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

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

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

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

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

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

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

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

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

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law,

automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

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

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

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

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

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

"Medically necessary" means that a service, drug, or supply is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient. A service, drug, or supply shall not be medically necessary if it: (i) is investigational, experimental, or for research purposes; or (ii) is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or (iv) could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or (v) involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration.

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

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

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

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

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

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

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

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

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

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

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

"Stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount.

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

§ 3. Operation of the Plan.

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

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

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

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

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

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

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

d. In its plan of operation the Board shall:

- (1) Establish procedures for selecting a Plan administrator in accordance with Section 5 of this Act.
- (2) Establish procedures for the operation of the Board.
- (3) Create a Plan fund, under management of the Board, to fund administrative, claim, and other expenses of the Plan.
- (4) Establish procedures for the handling and accounting of assets and monies of the Plan.

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

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

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

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

(e-5) The Board shall conduct a feasibility study of establishing a small employer health insurance pool in which employers may provide affordable health insurance coverage to their employees. The Board may contract with a private entity or enter into intergovernmental agreements with State agencies for the completion of all or part of the study. The study shall:

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

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

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

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

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

f. The Board may:

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

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

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

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

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

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

(7) Administer separate pools, separate accounts, or other plans or arrangements as required by this Act to separate federally eligible individuals or groups of federally eligible individuals who qualify for Plan coverage under Section 15 of this Act from eligible persons or groups of eligible persons who qualify for Plan coverage under Section 7 of this Act and apportion the costs of the administration among such separate pools, separate accounts, or other plans or arrangements.

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

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

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

§ 4. Powers and authority of the board.

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

- a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Director, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions including, without limitation, utilization review and quality assurance programs, or with health maintenance organizations or preferred provider organizations for the provision of health care services.
- b. Sue or be sued, including taking any legal actions necessary or proper.
- c. Take such legal action as necessary to:
 - (1) avoid the payment of improper claims against the plan or the coverage provided by or through the plan;
 - (2) to recover any amounts erroneously or improperly paid by the plan;
 - (3) to recover any amounts paid by the plan as a result of a mistake of fact or law; or
 - (4) to recover or collect any other amounts, including assessments, that are due or owed the Plan or have been billed on its or the Plan's behalf.
- d. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves, and formulas and any other actuarial function appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.
- e. Issue policies of insurance in accordance with the requirements of this Act.
- f. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the plan.
- g. Borrow money to effect the purposes of the Illinois Comprehensive Health Insurance Plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets.
- h. Establish rules, conditions and procedures for reinsuring risks under this Act.
- i. Employ and fix the compensation of employees. Such employees may be paid on a warrant issued by the State Treasurer pursuant to a payroll voucher certified by the Board and drawn by the Comptroller against appropriations or trust funds held by the State Treasurer.
- j. Enter into intergovernmental cooperation agreements with other agencies or entities of State government for the purpose of sharing the cost of providing health care services that are otherwise

authorized by this Act for children who are both plan participants and eligible for financial assistance from the Division of Specialized Care for Children of the University of Illinois.

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

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

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

(A) premiums paid on behalf of covered persons;

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

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

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

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

(A) premiums paid on behalf of covered persons;

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

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

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

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

(3) such other accounts as may be appropriate.

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

§ 5. Plan administrator.

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

- (1) The Plan administrator's proven ability to handle other large group accident and health benefit plans.
- (2) The efficiency and timeliness of the Plan administrator's claim processing procedures.
- (3) An estimate of total net cost for administering the Plan, including any discounts or income the Plan could expect to receive or benefit from.
- (4) The Plan administrator's ability to apply effective cost containment programs and procedures and to administer the Plan in a cost-efficient manner.
- (5) The financial condition and stability of the Plan administrator.

b. The Plan administrator shall serve for a period of 5 years subject to removal for cause and subject to the terms, conditions and limitations of the contract between the Board and the Plan administrator. At least one year prior to the expiration of each 5-year period of service by the current Plan administrator, the Board shall begin to advertise for bids to serve as the Plan administrator for the succeeding 5-year period. Selection of the Plan administrator for the succeeding period shall be made at least 6 months prior to the end of the current 5-year period. Notwithstanding any other provision of this subsection, the Board at its option may extend the term of a Plan administrator contract for a period not to exceed 3 years.

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

- (1) establishment of a premium billing procedure for collection of premiums from Plan participants. Billings shall be made on a periodic basis as determined by the Board;
- (2) payment and processing of claims and various cost containment functions; and
- (3) other functions to assure timely payment of benefits to participants under the Plan, including:
 - (a) making available information relating to the proper manner of submitting a claim for benefits under the Plan and distributing forms upon which submissions shall be made, and
 - (b) evaluating the eligibility of each claim for payment under the Plan.

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

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

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

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

§ 6. Contents of Plan.

The Plan shall include, but is not limited to, the following:

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

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

§ 7. Eligibility.

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

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

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

(3) The absence of available health insurance coverage for a person under 19 years of age.

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

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

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

d. For persons qualifying for coverage in accordance with Section 7 of this Act, the Board shall, if it determines that such appropriations as are made pursuant to Section 12 of this Act are insufficient to allow the Board to accept all of the eligible persons which it projects will apply for enrollment under the Plan, limit

or close enrollment to ensure that the Plan is not over-subscribed and that it has sufficient resources to meet its obligations to existing enrollees. The Board shall not limit or close enrollment for federally eligible individuals.

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

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

(1.1) His or her prior coverage under a group health plan or health insurance coverage, provided or arranged by an employer of more than 10 employees was discontinued for any reason without the entire group or plan being discontinued and not replaced, provided he or she remains an employee, or dependent thereof, of the same employer.

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

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

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

(5) The Plan has paid a total of \$5,000,000 in benefits on behalf of the covered person.

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

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

(8) The person has or later receives other benefits or funds from any settlement, judgement, or award resulting from any accident or injury, regardless of the date of the accident or injury, or any other circumstances creating a legal liability for damages due that person by a third party, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or assets remaining from those sources in an amount in excess of \$300,000.

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

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

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

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

§ 7.1. Premiums.

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

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

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

(d) The Board, with the assistance of the Director and in accordance with appropriate actuarial principles, shall determine a standard risk rate by using the average rates that individual standard risks in this State are charged by at least 5 of the largest health insurance issuers providing individual health insurance coverage to residents of Illinois that is substantially similar to the coverage offered by the Plan. In determining the average

rate or charges of those health insurance issuers, the rates charged by those issuers shall be actuarially adjusted to determine the rate or charge that would have been charged for benefits similar to those provided by the Plan. The standard risk rates shall be established using reasonable actuarial techniques and shall reflect anticipated claims experience, expenses, and other appropriate risk factors for such coverage.

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

§ 8. Minimum benefits.

a. Availability. The Plan shall offer in a periodically renewable policy major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the Plan shall pay an eligible person's covered expenses, subject to limit on the deductible and coinsurance payments authorized under paragraph (4) of subsection d of this Section, up to a lifetime benefit limit of \$5,000,000. The maximum limit under this subsection shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board. Any person who otherwise would qualify for coverage under the Plan, but is excluded because he or she is eligible for Medicare, shall be eligible for any separate Medicare supplement policy or policies which the Board may offer.

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

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

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

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

(3) (Blank).

(4) Outpatient prescription drugs that by law require a prescription written by a physician licensed to practice medicine in all its branches subject to such separate deductible, copayment, and other limitations or

restrictions as the Board shall approve, including the use of a prescription drug card or any other program, or both.

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

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

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

(8) Use of radium or other radioactive materials.

(9) Oxygen.

(10) Anesthetics.

(11) Orthoses and prostheses other than dental.

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

(13) Diagnostic x-rays and laboratory tests.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) (Blank).

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

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

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

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

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

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

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

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

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

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

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

d. Deductibles and coinsurance.

The Plan coverage defined in Section 6 shall provide for a choice of deductibles per individual as authorized by the Board. If 2 individual members of the same family household, who are both covered persons under the Plan, satisfy the same applicable deductibles, no other member of that family who is also a covered person under the Plan shall be required to meet any deductibles for the balance of that calendar year. The deductibles must be applied first to the authorized amount of covered expenses incurred by the covered person. A mandatory coinsurance requirement shall be imposed at the rate authorized by the Board in excess of the mandatory deductible, the coinsurance in the aggregate not to exceed such amounts as are authorized by the Board per annum. At its discretion the Board may, however, offer catastrophic coverages or other

policies that provide for larger deductibles with or without coinsurance requirements. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

e. Scope of coverage.

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

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

f. Preexisting conditions.

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

(2) (Blank).

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

(4) Waiver: The preexisting condition exclusions as set forth in paragraph (1) of this subsection shall be waived to the extent to which the eligible person (a) has satisfied the exclusion under prior Comprehensive Health Insurance Plan coverage that was involuntarily terminated because of meeting a lower lifetime benefit limit and (b) has reapplied for Plan coverage within 90 days following an increase in the lifetime benefit limit set forth in Section 8 of this Act.

g. Other sources primary; nonduplication of benefits.

(1) The Plan shall be the last payor of benefits whenever any other benefit or source of third party payment is available. Subject to the provisions of subsection e of Section 7, benefits otherwise payable under Plan coverage shall be reduced by all amounts paid or payable by Medicare or any other government program or through any health insurance coverage or group health plan, whether by insurance, reimbursement, or otherwise, or through any third party liability, settlement, judgment, or award, regardless of the date of the

settlement, judgment, or award, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the covered person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, and by all hospital or medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

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

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

During the pendency of any action or claim that is brought by or on behalf of a covered person against a third party or its insurer, any benefits that would otherwise be payable except for the provisions of this paragraph (3) shall be paid if payment by or for the third party has not yet been made and the covered person or, if incapable, that person's legal representative agrees in writing to pay back promptly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness or injury. This agreement is to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

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

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

h. Right of subrogation; recoveries.

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

proceeding brought by the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurer that may be liable or (ii) institute and prosecute legal proceedings against any third party or the third party's insurer that may be liable for the sickness or injury in an appropriate court either in the name of the Plan or in the name of the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors.

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

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

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

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

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

discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction. The court may consider the nature and extent of the injury, economic and non-economic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The Plan shall pay its pro rata share of the attorney fees based on the Plan's recovery as it compares to the total judgment. Any reimbursement rights of the Plan shall take priority over all other liens and charges existing under the laws of this State with the exception of any attorney liens filed under the Attorneys Lien Act.

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