community-based organizations could help support enrollment, outreach and education in both the Health Insurance Marketplace and Medicaid. Assisters are Certified Application Counselors (CACs). For information on what it means, and how to apply, to be a CAC go to the Certified Application Counselor organization website.

102.1.2 Prior and Retroactive Coverage

When an applicant initially applies for coverage they may request that their coverage is backdated to cover service they may have received for up to three months prior to the month of their application. The first time children are approved for the Family Health Plans of All Kids Share or All Kids Premium, the children may be eligible for payment of medical services received from two weeks before the date of application until the date their coverage under All Kids begins.

If the participant requests that the provider bill the Department for medical services rendered during the retroactive or prior coverage period, the provider should verify eligibility first. Refer to Topic 108 HFS Medical Card – Eligibility Verification.

Unless otherwise noted in the program descriptions that follow, participants in HFS' Medical Programs receive a Form HFS 469, HFS Medical Card, or, a DCFS youth in care, a CFS 930-C, Notice of Medicaid Coverage for DCFS Clients.

102.2 Medical Assistance Program

The Illinois Medical Assistance Program is the program which implements Title XIX of the Social Security Act or Medicaid. It is administered by HFS under the Illinois Public Aid Code. The Department has statutory responsibility and authority for the formulation of medical policy in conformance with federal and state requirements.

102.3 The Family Health Plan Program

Revised Effective September 1, 2019

The Family Health Plan Program is a joint federal and state funded program operating under Title XIX and Title XXI of the Social Security Act, the Illinois Public Aid Code [305ILCS 5/1-1et seq.1] and the Children's Health Insurance Program Act [215ILCS 106] that authorizes the Department to administer an insurance program to assist families in providing medical coverage for their children. The Family Health Plan Program is comprised of four plans:

- All Kids Assist/FamilyCare Plan – All Kids Assist pays for a child's health care with no copayments or premiums from the participant. FamilyCare pays for a parent or caregiver relative's health care also with no copayments. Refer to Topic 114, Patient Cost-Sharing.
- All Kids Share Plan – this plan pays for a child's health care with a low copayment due from the participant on certain services. Refer to Topic 114, Patient Cost-Sharing.

114 Participant Cost-Sharing

Payments made by the Department to providers for services to eligible participants are considered payment in full. If a provider accepts a patient as a Medical Programs participant, the provider may not charge the participant for copayments, participation fees, deductibles, or any other form of patient cost-sharing, except as specifically allowed in this Topic or in Topic 113, Spenddown. In no other instance may any form of patient cost-sharing (e.g., primary TPL deductibles and co-payments) be charged to eligible participants for any covered services under any of the programs described in Topic 102 of this handbook.

Providers may not make arrangements to furnish more costly services or items than those covered by the Department on the condition that patients supplement payments made by the Department.

Providers can verify copayment information when checking participant eligibility. Information on how to verify participant eligibility can be found in Topic 108, HFS Medical Card – Eligibility Verification. Additional information may be found at 89 Ill. Adm. Code Section 140.402 and Section 148.90.

114.1 Copayments

Revised Effective September 1, 2019

Appendix 5 of this handbook identifies the eligibility categories, specific procedure codes/services subject to copayments, the copayment amounts and, if applicable, the annual copayment maximum.

Participants covered by All Kids Share, All Kids Premium Level I and Level 2 and Illinois Veterans Care may be charged Department authorized copayments for certain services performed in an office or home setting, pharmacy services, emergency room visits and inpatient/outpatient services.

Certain services and groups of individuals are not subject to copayments.

The following **services** are exempt from copayments:

- Visits scheduled for well–baby care, well–child care, or age appropriate immunizations
- Visits in conjunction with the Early Intervention Program
- Visits to health care professionals or hospitals made solely for radiology or laboratory services
- Family Planning services
- Speech therapy, occupational therapy, physical therapy
- Audiology services

- Durable medical equipment or supplies
- Medical transportation
- Eyeglasses or corrective lenses
- Hospice services
- Long term care services
- Case management services
- Preventive or diagnostic services
- Renal dialysis treatment
- Radiation therapy
- Cancer chemotherapy
- Insulin
- Services for which Medicare is the primary payer
- Pharmacy compounded drugs
- Prescriptions (legend drugs) dispensed or administered by a hospital, clinic or physician
- Preventive Services

In addition, the following individuals are exempt from copayments:

- Pregnant women, including a postpartum period of 60 days
- Children under the age of 19 covered under All Kids Assist
- Adults covered under Title 19
- Hospice patients
- American Indians and Alaskan Natives
- Non-institutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections
- Individuals enrolled in the Health Benefits for Persons with Breast or Cervical Cancer Program
- Residents of nursing homes, intermediate care facilities for the developmentally disabled and supportive living facilities
- Residents of a State-certified, State-licensed, or State-contracted residential care program

114.1.1 Collection of Copayments

Revised Effective September 1, 2019

The Department automatically deducts copayment amounts from the provider's reimbursement. When billing the Department, providers should bill their usual and customary charge and **should not** report the copayment on the claim.

Providers are responsible for collecting HFS medical programs' copayments from the participant. Providers may choose not to charge a copayment. However, if copayments are charged the copayment amount cannot exceed the amounts show in Appendix 5.

Federal regulations stipulate that for certain low-income individuals, a provider cannot deny services due to the person's inability to pay a copayment. This requirement **does not apply** to participants in the following programs:

- All Kids Share
- All Kids Premium Level 1
- All Kids Premium Level 2
- Veterans Care

Providers may apply their office policies/practices relating to copayments to participants covered under these three programs.

114.1.2 Annual Copayment Maximum

Under the All Kids Share, All Kids Premium Level 1 and Premium Level 2 plans copayments are capped at a maximum out of pocket expense for a family during a 12 month eligibility period. Families are responsible for collecting copayment receipts and submitting the receipts to the Department once they have reached their cap. Upon determining that the copayment cap has been satisfied, the Department will send a notice to the family stating that the copayment cap has been satisfied as of a specific date. The MEDI and REV/EDI systems are also updated to reflect that the copayment cap has been reached. Providers are responsible for refunding the family any copayments they collect after the family has reached the annual copayment maximum.

114.2 Medicare Coinsurance and Deductibles

Medical Program participants may not be charged for Medicare co-insurance and deductibles, regardless of whether the Department pays all, some or none of the charges. Refer to Topic 120, Other Payment Sources, for further details.

114.3 Monthly Premiums

Participants of the All Kids Premium Level 1 and Premium Level 2 plans will have a monthly premium for their coverage. The amount of the monthly premium is based on income, the size of the family and how many children are covered.

114.4 State Chronic Renal Disease Program Participation Fee

Participants in the State Chronic Renal Disease Program may be responsible for payment of a portion of the cost of covered dialysis services. This is referred to as the patient's monthly participation fee. The fee is determined by the Department on

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General Appendix 5
Cost-Sharing for Participants

Service	**All Kids Assist** 0%-147% (142% plus 5%)	**All Kids Share*** 148%-157%	**All Kids Premium Level 1*** 158%-209%	**All Kids Premium Level 2*** 210%-318% (313% plus 5%)	**Moms and Babies/ Medicaid Presumptive Eligibility (MPE)** 0%-209% (204% plus 5%)	**Aid for the Aged, Blind or Disabled** 0% - 100% (Resources - $2,000 to $3,000)	**Health Benefits for Workers with Disabilities** 100% - 350% (Resources to $25,000)	**Family Care and ACA Adults** 0%-138% (133% plus 5%)	**Breast and Cervical Cancer Program**	**Illinois Veterans Care**
CPT Codes 99201 – 99215	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	$15.00/visit
CPT Codes 99241 – 99245	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	$15.00/visit
CPT Codes 90791 – 90911	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	$15.00/visit
CPT Codes 92002 – 92014	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	$15.00/visit
CPT Codes 98940 – 98943	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	Not Covered
T1015 (Medical or Dental Encounter)	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	$15.00/visit
T1015 (Behavioral Health Encounter)	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	$15.00/visit
Family Planning Services Billed with Modifier FP	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Restorative Dental Visits	$0	$3.90/visit	$5.00/visit	$10.00/visit	$0	$0	$0	$0	$0	$15.00/visit
Prescription Drugs (Per 30-day supply)	$0	Brand $3.90 Generic $2	Brand $5 Generic $3	Brand $7 Generic $3	$0	$0	$0	$0	$0	Brand $14 Generic $6
Over-the-Counter (OTC) Medications	$0	$2.00/drug	$3.00/drug	Not covered	$0	$0	$0	$0	$0	Not Covered
Emergency Room Visit	$0	$0	$5.00/visit	$30.00/visit	$0	$0	$0	$0	$0	$50.00/visit
Emergency Room Visit for Non-emergent Service	$0	$0	$25.00/visit	$30.00/visit	$0	$0	$0	$0	$0	$50.00/visit
Hospital Inpatient Services (Including substance abuse & mental health services)	$0	$3.90/day	$5.00/day	$100/ admission	$0	$0	$0	$0	$0	$150/ admission
Hospital Outpatient Services	$0	$3.90/visit	$5.00/visit	5% of HFS rate	$0	$0	$0	$0	$0	10% of HFS rate
Annual Copayment Maximum	$0	$100 per family	$100 per family	$500 per child	$0	$0	$0	$0	$0	$0

*****No co-payment for Well-Child, Immunizations, Preventive Services, Diagnostic Services or Family Planning. Family planning related medical services require a co-pay for office visits. Claims for well child and family planning visits must be submitted with modifiers "EP" (EPSDT) or "FP" (Family Planning).

Note: Copayments are exempt for services for which Medicare is the primary payer.