

OKLAHOMA HEALTH INSURANCE HIGH RISK POOL (OHRP)

ORIGINAL POLICY version 104

Oklahoma Health Insurance High Risk Pool (OHRP) offers an insurance plan to provide health care benefits for Oklahomans who are **MEDICALLY ELIGIBLE** or **FEDERALLY ELIGIBLE**. This brochure contains only a brief description of benefits, for full details see the policy.

The program administrators work with a network of physicians, hospitals and other health care providers to ensure that OHRP insureds receive high-quality care in the most cost-efficient manner and setting possible. When OHRP insureds receive covered health care services from network providers, program benefits are reimbursed at a higher percentage. For out of network providers the percentage is lower and subject to other significant reductions required by law, which are noted more fully in the Oklahoma Health Insurance High Risk Pool Act (which governs this program) and the policy. Note also, not every provider in the State of Oklahoma is in the network, but because the network is an in State only network, providers out of State are almost entirely out of network.

In addition to the network, OHRP has several other cost-management features including Pre-Certification for certain services listed in the policy, including but not limited to Pre-admission Authorization.

MEDICAL ELIGIBILITY- subject to 12 month pre-existing condition exclusion

Applicants must be residents of the State of Oklahoma and the State must have been their primary residence for the preceding twelve months. Applicants must have applied for health insurance and been rejected by two carriers for similar coverage or have a letter from a physician verifying they currently have one of the conditions listed on the Conditions List included with this brochure. Rejection usually means refusal to issue any policy, but it can also mean being offered coverage at substantially more than the OHRP rate, or an offer of coverage with material and permanent underwriting restrictions.

Also, applicants must not have or be eligible for health insurance through an employer-sponsored group or self-insured plan or through continuation of such coverage or individual coverage and is not eligible for any other public or private program that provides or indemnifies for health services; AND

Applicants must not be in either Part A or Part B (or both) of Title XVIII of the Social Security Act (Medicare). Applicants must not be in a State plan under Title XIX of such Act (Medicaid).

FEDERALLY DEFINED ELIGIBILITY

Applicants must be residents of the State of Oklahoma when they apply. Applicants **MUST** apply within 63 days of the exhaustion of COBRA (if available) or State continuation plan. AND

Applicant, as of the date on which the individual seeks coverage under this Plan, has aggregate creditable coverage of 18 months or more; AND

Applicant's most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan; AND

Applicant is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare) or a State plan under Title XIX of such act (Medicaid) or any successor program, and does not have other health insurance coverage; AND

Applicant's most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment or premiums or fraud; AND

With respect to whom the most recent coverage under a COBRA continuation provision or under a similar state program, elected such coverage; AND

Who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described above in this paragraph.

Applicant must provide letters of creditable coverage.

**OKLAHOMA HEALTH INSURANCE HIGH RISK POOL SCHEDULE OF BENEFITS
ORIGINAL POLICY**

Calendar Year Deductible Amount Options: \$500 \$1,000 \$1,500 \$2,000 \$5,000 \$7,500

BENEFIT CATEGORY	THE PLAN PAYS	YOU PAY
Overall Deductible	None of the chosen deductible amount	All Eligible Expenses up to the deductible chosen
Coinsurance Percentage for Eligible Expenses* * see note below	80% of Allowable Charges in-network, 60% of Allowable Charges out-of-network	20% of Allowable Charges in-network; 40% of Allowable Charges out-of-network
Out-of-Pocket Expense Amount	For Eligible Expenses over \$10,000 (after Deductible) the plan pays 100% of Allowable Charges	0% of the Allowable Charges for Eligible Expenses over \$10,000. You pay all of the non-covered charges you incur.
Lifetime Benefit Maximum	\$500,000	All Eligible Expenses once OHRP has paid \$500,000 in benefits to you in your lifetime
This is a brief description see the policy for details		

BENEFIT CATEGORY	SPECIAL BENEFIT LIMITS OR RESTRICTIONS	Does the deductible apply before this benefit is payable?	Does the regular coinsurance apply to this benefit?	Do your Co-payments help satisfy the Out of Pocket Expense Amount?
The benefits shown below are just a few of the many benefits with special limits or restrictions. For full details of benefits, see the Policy.				
Outpatient Prescription Drugs Program Retail-- 30 day supply In network only	\$10 Co-pay for generic drugs; \$20 Co-pay for Preferred drugs; 30% of drug cost or \$30 Co-pay, whichever is greater, for Non-Preferred drugs. ***	No	No	No
Mail order drugs (90 day supply) In network only	\$20 Co-pay for generic, \$40 Copay for Preferred, 30% of drug cost or \$30 co pay, whichever is greater, for NonPreferred	No	No	No
the copays above do not apply to biotech drugs - listed as such by the pbm	(in network only)	No	No	No
Biotech drugs- are as follows Retail (30 day supply) Mail Order (60 day supply)	\$100 copay \$150 copay			
Mental and Nervous Alcoholism and Drug Addiction: Inpatient or Outpatient Combined	50% copay up to a maximum of \$4,000 annually	No	No	No

SURGERY, HOSPITAL AND OTHER SERVICES NEED TO BE PRE-CERTIFIED FOR BENEFITS, see the Policy for details.

*Benefits are payable at the 80% of Allowable Charges level for.

(1) Services provided by network providers and (2) Emergency services

Care from non-network providers is payable at 60% of Allowable Charges.

**The prescription drug program is provided through a Pharmacy Benefit Manager Network (PBM).

***Mandatory Generic Program: At dispensing, based on the availability of a generic drug, should there, in fact, be a generic drug available and yet the plan participant requests the dispensing be filled with a name brand drug, then he/she pays the generic co-pay plus the difference between the generic and the name brand drug. This co-pay applies to both retail and mail service dispensings.

Categories of Covered Services Include (these are just categories, for benefits and full details of coverage including exclusions and limitations, see the policy)

Hospital services, Surgical/Medical services, Outpatient Diagnostic services (including mammography screening), Outpatient Therapy services, Maternity, Human Organ and Tissue Transplant services, Ambulatory Surgical Facility services, Mental and Nervous/Alcoholism/Drug Addiction Treatment, Ambulance services, Skilled Nursing Facility services, Home Health Care services, Oral Surgery services, Prescription Drugs, Durable Medical Equipment, Supplies and Related services for the Treatment of Type I, Type II and Gestational Diabetes, Prosthetic Appliances, Elective Sterilization, Reconstructive Breast Surgery, Audiological services, Prostate screening, Special Anesthesia Expenses, Wigs or Scalp Prosthesis

Services Not Covered

The following is a **partial listing** of some of the services that are not covered by the OHRP program. For full details of all limitations and exclusions, see the Policy.

Care that would otherwise be covered under a government program
Care for any condition resulting from War or any act of War when serving in the military or auxiliary unit thereto
Services provided after termination of the OHRP coverage
Care that is not expressly specified in the OHRP Health Care Individual Contract
Experimental/Investigational services and supplies
Acupuncture, homeopathy and naturopathy
Personal supplies or services which are non medical or non-prescribed
Eyeglasses or hearing aids or examinations for their prescription or fitting unless in conjunction with operative treatment for cataracts
Convalescent, domiciliary or custodial care
Intentionally self-inflicted injury, or injury or sickness occurring as a result of taking part in a felony
Injury or sickness covered by Workers' Compensation, occupation disease law or similar laws whether or not you claim those benefits
Eye surgery if corrective lenses would alleviate the problem
Cosmetic surgery other than for injuries or conditions which occurred while this policy was in force

Cost-Management Provisions

These cost-management features are designed to reduce unnecessary and inappropriate use of health care services.

Pre-Certification: There are pre-certification requirements for Inpatient Admission, any Outpatient Surgery, Home Health Care Services, Private Duty Nursing, Skilled Nursing, Extended Care, Hospice, ongoing Physical Therapy, Rehabilitative Care and Human Organ and Tissue Transplant Services and Invasive Testing.

The Insured must receive pre-certification from the plan in order for benefits to be considered under this contract. The Plan has the sole and final authority for approving or declining requests for pre-certification. The decision will be based upon the Plan's review of supporting medical evidence, stating the diagnosis, the recommended course of treatment, the name of the attending physician and the name of the facility in which the service will be rendered.

The pre-certification number to call is on the medical ID card. Contact pre-certification as soon as possible, but at least three days prior to any Hospital Admission or any other service requiring pre-certification. However, in the case of an emergency treatment that would normally require pre-certification, notification to the plan must be made within 72 hours of the emergency that caused the treatment. **Do not delay emergency care while awaiting certification.**

Emergency care is care provided for the treatment of a sudden medical condition manifesting itself by symptoms that require immediate medical attention, which should pose a threat to life or limb if left untreated.

FAILURE TO COMPLY WITH PRE-CERTIFICATION REQUIREMENTS IS SUBJECT TO REDUCTION OF BENEFITS OF THE LESSOR OF 20% OR \$5,000.00 PER COVERED SERVICES. THIS WILL BE IN ADDITION TO YOUR DEDUCTIBLES AND CO-PAYMENTS.

Concurrent Review, Discharge Planning and Retrospective Review: Hospital confinements and costs are closely monitored both during and after a hospital stay. If it is determined that hospital care is no longer required, both the member and the physician will receive written notification. The member is encouraged to leave the hospital or to use alternative, less costly type of care if necessary. Additionally, certain inpatient claims are reviewed after payment to ensure that they were paid appropriately and to identify any unusual patterns in use of health care services.

Pre-existing Condition Limitations- This limitation applies to medical and pharmaceutical benefits, and does not apply to federally qualified individuals.

Your policy will not cover expenses incurred during the first 12 months after its Policy Date for a pre-existing condition. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment (including prescription medications) was recommended or received within the six month period ending on the enrollment date.

We will pay only for Eligible Expenses incurred after such 12 month period. Payment will be in accord with the provisions of this policy. However, if you had continuous coverage for the pre-ceding six months before the Pool coverage effective date, under another similar policy which provided major medical expense benefits, which did cover or could have covered a pre-existing condition and you applied for Pool coverage within 63 days of the termination of that prior coverage, the pre-existing condition limitation will be waived for that same pre-existing condition only.

This brochure contains only a summary of benefits and exclusions of the Oklahoma Health Insurance High Risk Pool (OHRP) program. Complete details of benefits and exclusions and the terms under which they are provided are contained in the OHRP benefit booklet (policy contract) issued to the member when his or her coverage is approved. If a discrepancy occurs between this brochure and the policy contract, the policy contract, as governed by the Oklahoma Health Insurance High Risk Pool Act, is the authority.

Referring agents are not authorized to amend or alter the terms of the OHRP insurance policy contract, nor are referring agents authorized to bind OHRP in any way. OHRP coverage can be continued for a covered person only while he/she remains a resident of the State of Oklahoma. If you are considering replacing other coverage with this coverage because of the other plans higher rates, we recommend that you thoroughly examine and compare both plans. There probably will be aspects of the other policy that provide better benefits than this policy.

FOR MORE INFORMATION CALL 1-800-255-6065 Ext. 4767

HOW TO APPLY

Complete the enclosed OHRP Application for Coverage and submit it with the first month's premium. Applicants applying on the basis of MEDICAL ELIGIBILITY and those applying on the basis of FEDERALLY DEFINED ELIGIBILITY must attach different documentation.

MEDICAL ELIGIBILITY Documentation

You must provide one of the following to document 12-months residency in Oklahoma:

- recent Oklahoma tax returns, or
- 12-month old Oklahoma driver's license showing current Oklahoma address; or
- 12-month old utility bill showing current Oklahoma address.

If you have been diagnosed with one of the conditions identified on the current conditions list in this brochure provide a letter from your physician.

If you have been rejected for health care coverage by at least two insurance carriers, include a letter or form from the authorized representatives of two Oklahoma-licensed health insurers or health plans documenting the underwriting action taken. This documentation must indicate that the coverage was refused.

If you are being charged substantially more than the OHRP Plan's rates for an individual plan health care coverage, include the premium bill from your insurer.

If you have been accepted for health insurance coverage but are subject to a permanent exclusion or waiver of a pre-existing condition or disease, include the policy form that indicates the exclusion of coverage for specific conditions.

FEDERALLY DEFINED ELIGIBILITY Documentation

A certificate of creditable coverage from all previous insurers the aggregate of which is 18 months. Evidence of election of COBRA and the exhaustion of COBRA or other State Continuation program.

If applicant's most recent coverage within the period of aggregate creditable coverage was terminated for reasons other than non-payment of premiums or fraud, attach a certificate of canceled coverage indicating the termination reason and termination date.

Note: Your first month's premium must be submitted with your application. Checks should be made payable to Oklahoma High Risk Pool.

Notification of Acceptance or Denial of Coverage: If your OHRP Application for Coverage meets all program requirements, the OHRP Administrator will notify you of your acceptance or denial. A benefit booklet and identification card will be issued to each applicant who is accepted.

Effective Dates and Premium Payments: Eligible applicants who are accepted for OHRP will be notified of their effective date of coverage. Premiums may be paid by direct bill or automatic withdrawal. You must notify the Administrator, complete and return the proper forms to set up automatic withdrawal.

You may apply through an Oklahoma licensed insurance agent, but an agent is not required to apply. You may apply directly to the OHRP plan Administrator.

MAIL THE APPLICATION TO:

The Epoch Group, attention OHRP,
PO Box 12170,
Overland Park, KS 66282-2170

1-800-255-6065 Ext. 4767

CURRENT MEDICAL CONDITIONS LIST

One of several requirements for Medical Eligibility is having been rejected by two companies for similar coverage. If an applicant currently has one of the conditions listed below, he/she may submit, in lieu of the two rejection requirement, a letter from a physician verifying the applicant has the condition.

Cancer- Bone, Brain, Breast, Colon, Liver, Lung

Cardiovascular- Artificial Heart Valve, Cardiomyopathy, Coronary Atherosclerotic Disease which was symptomatic with MI, Polyarteritis Nodosa

Endocrine/Exocrine- Cystic Fibrosis, Diabetes Mellitus

Gastrointestinal Intestinal- Crohn's Disease, Ulcerative Colitis

Hematopoietic- Aplastic Anemia, Hemophilia, Hodgkin's Disease, Leukemia, Sickle Cell Disease

Immunological-ADA (Adenosine deaminase deficiency), AIDS or HIV positive, Ataxia – Telangiectasia, SCID (Severe-combined immunodeficiency disease), Scleroderma, Systemic lupus erythematosus, Wegener's granulomatosis, X-linked agammaglobulinemia

Liver-Cirrhosis (non-alcoholic), Hepatitis C, Wilson's Disease

Musculoskeletal-Dermatomyositis or polymyositis Muscular dystrophy

Neurological / Central Nervous System - Alzheimer's Disease, Cerebral Palsy, Cerebrovascular Accident (CVA), Developmental disability (mental retardation), Encephalitis (active or resulting impairment), Hydrocephalus, Lobotomy (accidental or surgically induced), Parkinson's disease (if treatment in past 3 years), Seizure disorder (symptomatic in past 3 years)

Neurological / Peripheral Nervous System (including spinal cord)- Amyotrophic Lateral Sclerosis (ALS), Paraplegia or Quadriplegia, Sclerosis, Multiple, Disseminated or Postero-Lateral Syringomyelia (spina bifida)

Pulmonary- Asthma (steroid dependent), Bronchopulmonary dysplasia, Chronic Obstructive Pulmonary insufficiency, oxygen dependent, Pulmonary Fibrosis with pulmonary insufficiency

Renal-Chronic renal failure, with or without dialysis, Polycystic kidney

If you have questions after reading all information provided, please contact:

The EPOCH Group, L.C. Attention: OHRP P.O. Box 12170, Overland Park, Kansas 66282-2170

1-800-255-6065 Ext. 4767

OKLAHOMA HEALTH INSURANCE HIGH RISK POOL APPLICATION- - ORIGINAL POLICY

Please print all information.

Applicant information				Requested Effective Date:	
1. A.	Name: Last	First	Middle I	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth M/D/Y
B.	Address: Number	Street	City	State	ZIP County
C.	Telephone Number			Social Security No.	
D.	Person whom OHRP may contact in an emergency: Name: Last First Middle			Relationship to you	
E.	Address: Number	Street	City	State	ZIP Telephone No. ()
F.	Name and address of your employer, if any:				Employer's telephone number ()
G.	Are you now totally disabled? If "Yes", please describe your disability. Yes No				

2. Spouse / Dependents Desiring Coverage

	IDENTIFY RELATIONSHIP	NAME (First, M.L, Last if Different from Applicant)	Social Security Number	BIRTH DATE (Mo-Day-Yr)
M F	SPOUSE			
M F	DEPENDENT 1			
M F	DEPENDENT 2			
M F	DEPENDENT 3			
M F	DEPENDENT 4			

3. OHRP Deductible Selection. Please select the deductible amount you want. Note: Your Spouse and Dependents, if covered, will each have the same deductible you select. Each one must satisfy their individual deductibles in each Calendar Year (subject to the family deductible provisions in the Schedule of Benefits).

\$500
 \$1,000
 \$1,500
 \$2,000
 \$5,000
 \$7,500

4. Current Health Care Coverage Information

- A. Are you employed? Yes No Is your spouse employed? Yes No
- B. Are you covered by group insurance through your employer? Yes No
- Are you covered by group insurance through your spouse's employer? Yes No
- C. Are you currently enrolled in, or eligible for, Medicare or Medicaid? Yes No
- D. Have you previously had company sponsored coverage terminated? Yes No
- E. Do you have health insurance presently in force? Yes No

If the insurance to be issued is intended to replace any other accident and health insurance and/or you answered "Yes" to any question, please complete sections F and G below. Attach an extra sheet if necessary. If you answered "No", go on the next section.

F. Name of Primary Person Covered	Name of Insurance Co.	Is this coverage provided by:
_____	_____	Your Employer? Spouse Employer?
_____	_____	Yes ___ No ___ Yes ___ No ___
		Yes ___ No ___ Yes ___ No ___

G. Have you had continuous coverage under another policy with respect to the given pre-existing condition up to the date of this application? Yes ___ No ___

If you answered "Yes", please complete all information below. If "No", go on to section 6.

Name, Address and Phone Number of Insurance Company	Period of Coverage	Policy Number
_____	_____	_____
_____	_____	_____

5. Are you eligible for or currently covered under COBRA? _____ (if yes give dates of coverage) _____

6. Eligibility

I am eligible for coverage with OHRP for the following reasons:

___ I am applying for OHRP because of **MEDICAL ELIGIBILITY** please sign AFFIRMATION FORM #1

___ I am applying for OHRP coverage because I no longer have or am about to lose group health insurance, COBRA or other coverage and am not eligible for Medicare or Medicaid and I satisfy the definition of a **FEDERALLY DEFINED ELIGIBLE** individual. Please sign AFFIRMATION FORM #2.

X _____ Date: _____

Applicant's Signature if 15 or older
(Parent's or Legal Guardian's Signature for children under 15)

It is not required that you have an insurance agent involved in this application process for OHRP, so you can leave blank the agent's statement below. However, if an agent assists in the process, please ask the agent to complete the following statement.

Agent's Statement: I have a valid agent's or broker's license in the state of Oklahoma for accident and health insurance. I have assisted the applicant in completing this application for coverage with OHRP. To the best of my knowledge and belief the information contained in the application and this affirmation form is correct and complete. I certify that the applicant meets the OHRP eligibility standards.

_____	_____	_____	_____
Print Agents Name	Agent SS Number / Tax ID	Agency	Phone Number
_____	_____	_____	_____
Agent's signature	Address	City/State	Zip

OKLAHOMA HEALTH INSURANCE HIGH RISK POOL HEALTH STATEMENT

Your health status does not disqualify you for the OHRP program. However, your answers to these questions are important to the operation of the program.

Each of the following questions must be answered "Yes" or "No". In addition, each condition which caused you to answer "Yes" must be circled, and described on the next page.

Your policy will not cover expenses incurred during the first 12 months after its Effective Date of Coverage for a pre-existing condition. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment (including prescriptions) was recommended or received within the six month period ending on the enrollment date. This provision does not apply to federally qualified individuals.

During the past two years, have you had or been advised of, positively diagnosed with, or treated for any of the following conditions?

1. Anemia, other blood disease or disorder Yes No
2. Arthritis, lupus, gout or any inflammation, recurrent pain or diminished range of motion in the joints, including knees or hips (please indicate the specific problem on the following page) Yes No
3. Back, neck or spinal column disorders, including back adjustments recurrent back pain or immobility Yes No
4. Bladder infections, kidney infections, kidney stones, or any other bladder, kidney or urinary disorder Yes No
5. Breast disorder, fibrocystic disease, breast implant or reduction Yes No
6. Cancer, cysts, tumors, polyps, or other growths Yes No
7. Congenital disease or birth defect Yes No
8. Diabetes, goiter or thyroid disorder or disorder of the glands Yes No
9. Acquired Immune Deficiency Disorder (AIDS) or related complex (ARC) Yes No
10. Eating disorder, such as anorexia or bulimia Yes No
11. Emphysema, bronchitis or any chest, lung or respiratory problem or disorder Yes No
12. Epilepsy, seizures, migraine or recurrent headaches Yes No
13. Fractures, dislocations, polio, loss of limb(s), bone disorders (On the following page, please indicate the involved limb(s) [left or right, arm or leg] and if screws, pins or plates are now in place.) Yes No
14. Gallstones, gallbladder disorder; hernia (except hiatal) Yes No
15. Sexually-transmitted diseases, such as genital herpes, syphilis, gonorrhea, chlamydia or venereal warts Yes No
16. Heart murmur, irregular heartbeat, rheumatic fever, chest pain, heart valve problem, heart attack or any other heart condition Yes No
17. Hepatitis, cirrhosis or any other liver disorder Yes No
18. Disorder of the male or female reproductive organs, including enlarged prostate, prostatitis, menstrual irregularity or disorder, fibroid uterus, abnormal pap smear or ovarian cyst Yes No
19. Pregnancy Yes No
20. Muscular or neurological disorder, such as muscular dystrophy, multiple sclerosis, cerebral palsy or Parkinson's Yes No
21. Nervous, mental or emotional condition; attempted suicide, depression or mental retardation Yes No
22. Paralysis, stroke, TIA or high blood pressure Yes No
23. Ulcers, colitis, hemorrhoids, ulcerative colitis, Crohn's, hiatal hernia or any other stomach, intestine, bowel or rectal disorder Yes No
24. Varicose veins, clots, poor circulation or any other vein/artery disorder Yes No

During the past two years, have you:

25. Had an operation or been hospitalized? Yes No

26. Been treated or counseled for alcoholism, the use of alcohol, drug abuse or the use of drugs? ___ Yes ___ No

27. Had any other condition, disorder, ailment or injury not listed above for which you have had or plan to seek advice, diagnosis or treatment? ___ Yes ___ No

28. Consulted a doctor, chiropractor, therapist or other health care provider? ___ Yes ___ No

29. If you answered "Yes" to any of the questions number 1-28, complete this section. Give complete details, including the number of each item that you answered "Yes". Attach an additional sheet of paper if necessary.

Item No.	Dates of illness or Conditions or Symptoms	Diagnosis, Treatment, Medication or Reason for Visit	Is further treatment needed?	Were you hospitalized?	Name and Address of Doctor and/or Hospital
	From		-Yes	-Yes	
	To		No	No	
	From		-Yes	-Yes	
	To		No	No	
	From		-Yes	-Yes	
	To		No	No	
	From		-Yes	-Yes	
	To		No	No	

30. Have you taken prescribed medications within the last year? ___ Yes ___ No

If "Yes", please describe below.

Medicine	Dosage	Reason	Name/ Address of Prescribing Doctor

31. Your Current primary physician:

Name: _____

Specialty: _____

Address: _____

Telephone: _____

City, State, Zip: _____

32. Has future surgery, diagnostic testing or medicinal treatment been recommended or discussed for you? ___ Yes ___ No

If "Yes", complete the following section.

Date _____ Diagnosis _____

Type of operation or treatment? _____

X _____ Date: _____

Signature of Applicant or Parent or Legal Guardian – Note: If the applicant is under 15 years of age, a parent or legal guardian must sign above to indicate consent.

AFFIRMATION FORM #1
MEDICAL ELIGIBILITY

Please read carefully and sign below.

I hereby apply for OHRP coverage, as offered by the Oklahoma Health Insurance High Risk Pool. I understand and agree to everything listed below:

I certify that all the information I provided on this application is true and complete.

I will pay monthly the premiums billed by OHRP for the benefits that I requested.

If my premiums are not paid within 31 days after the due date, my coverage will end as of the date payment was due.

Any hospital, doctor or other provider of health care services is hereby authorized to release all necessary medical information about my care.

I understand that if I am eligible for OHRP because of medical eligibility, benefits will not be payable during the first 12 months after coverage is effective, for any condition for which medical advice, diagnosis, care or treatment (including prescription medication) was recommended or received during the six month period immediately preceding the effective date of coverage.

I certify that I have been a resident of Oklahoma for at least twelve months prior to making this application.

Proof of my residency (copy of driver's license and/or Oklahoma tax return and/or utility bill) is attached to this application.

I am eligible for coverage with OHRP for the following reasons (please check each that apply):

I have applied for health insurance and been rejected by two carriers because of health conditions;

I have applied for health insurance and been quoted a rate for coverage substantially more than the Pool's rate; or

I have been accepted for health insurance subject to a permanent exclusion or waiver of a pre-existing disease or condition.

I have a listed condition.

I understand that my OHRP Contract can be canceled if I provide any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive. I understand that this is an application only. I will be notified in writing if I am accepted into the OHRP Program. I understand that I must initial and date any changes I make while I am completing this application.

I will be responsible for obtaining Pre-admission Authorization prior to any non-emergency admission to a hospital or alcoholism treatment facility, and within 72 hours after an emergency admission.

I will let OHRP know if and when I am no longer eligible for OHRP coverage, such as, because I change residence, become eligible for Medicare, or begin receiving Medicaid benefits. Failure to do so will result in repayment of any and all benefits provided to the insured which were paid after the insured failed to meet eligibility requirements.

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable by this or any other Plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. A photocopy of this authorization shall be valid as the original.

X _____ Date _____

Applicant's Signature if 15 or older (Parent or Legal Guardian's Signature for children under 15)

Signature of Witness _____ **Date** _____

AFFIRMATION FORM #2
FEDERALLY DEFINED ELIGIBILITY

Please read carefully and sign below.

I hereby apply for OHRP coverage, as offered by the Oklahoma Health Insurance High Risk Pool. I understand and agree to everything listed below:

I certify that all the information I provided on this application is true and complete.

I will pay monthly the premiums billed by OHRP for the benefits that I requested.

If my premiums are not paid within 31 days after the due date, my coverage will end as of the date payment was due.

Any hospital, doctor or other provider of health care services is hereby authorized to release all necessary medical information about my care.

I understand that my OHRP Contract can be canceled if I provide any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive.

I understand that this is an application only. I will be notified in writing if I am accepted into the OHRP Program.

I understand that I must initial and date any changes I make while I am completing this application.

I will be responsible for obtaining Pre-admission Authorization prior to any non-emergency admission to a hospital or alcoholism treatment facility, and within 72 hours after an emergency admission.

I will let OHRP know if and when I am no longer eligible for OHRP coverage, such as, because I change residence, become eligible for Medicare, or begin receiving Medicaid benefits.

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable by this or any other Plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. A photocopy of this authorization shall be valid as the original.

X _____ Date _____

Applicant's Signature if 15 or older (parent or Legal Guardian's Signature for children under 15)

Signature of Witness _____ **Date** _____

Do you have any of the following conditions?

	Insured	Spouse	Dep. 1	Dep. 2	Dep. 3
CHF (Congestive Heart Failure)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
CAD (Coronary Artery Disease)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Spinal Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Kidney Failure and other Renal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Brain or Spinal Cord injury	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
COPD (Chronic Obstructive Pulmonary Disorder)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Neurological/Neuromuscular Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Mental Health Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Use the back of this page for additional dependents.

Oklahoma High Risk Pool
ORIGINAL PLAN

Effective Date: October 1, 2004
Monthly Premium Rates

Attained Age	\$500 Deductible		\$1,000 Deductible		\$1,500 Deductible		\$2,000 Deductible		\$5,000 Deductible		\$7,500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-3	\$ 246.06	\$ 271.23	\$ 194.09	\$ 215.09	\$ 167.78	\$ 186.44	\$ 139.50	\$ 155.46	\$ 101.36	\$ 112.20	\$ 86.46	\$ 95.50
4-18	233.97	259.13	184.25	205.25	158.73	177.39	131.04	147.00	95.33	106.17	81.41	90.44
19-24	302.45	514.89	240.01	413.30	208.54	363.20	180.26	318.32	129.01	222.98	110.33	188.44
25-29	311.34	545.58	247.63	437.57	216.57	383.96	186.62	336.14	133.80	236.73	114.42	201.32
30-34	349.06	569.96	279.87	458.07	243.49	401.80	209.34	353.81	150.09	252.35	127.30	214.46
35-39	408.22	639.12	331.81	519.26	288.15	455.79	249.69	400.65	178.07	286.12	152.47	243.43
40-44	488.39	706.16	399.43	580.53	349.61	513.15	305.89	453.91	221.71	328.89	189.11	281.28
45-49	619.85	782.59	513.04	651.45	450.30	573.50	392.58	509.17	289.69	368.19	247.71	315.30
50-54	808.14	890.01	674.19	751.54	589.50	661.55	513.98	588.67	378.52	427.66	323.33	367.07
55-59	1,046.51	1,005.57	872.84	856.15	756.65	754.44	655.87	670.95	481.14	493.05	409.54	421.72
60-64	1,319.15	1,126.66	1,096.46	983.81	947.94	854.15	817.59	754.67	598.53	555.95	509.91	476.18
65+	1,479.01	1,226.00	1,229.21	1,048.40	1,062.75	929.08	916.48	820.50	670.50	603.70	571.09	516.88
1 Child	198.33	198.33	154.10	154.10	131.83	131.83	109.79	109.79	79.55	79.55	67.48	67.48
2 Children	392.94	392.94	305.20	305.20	261.06	261.06	217.65	217.65	157.87	157.87	133.96	133.96
3+ Children	591.27	591.27	459.30	459.30	392.89	392.89	327.44	327.44	237.43	237.43	201.43	201.43

ORIGINAL PLAN
Annual Premium Rates

Attained Age	\$500 Deductible		\$1,000 Deductible		\$1,500 Deductible		\$2,000 Deductible		\$5,000 Deductible		\$7,500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-3	\$ 2,952.72	\$ 3,254.76	\$ 2,329.08	\$ 2,581.08	\$ 2,013.36	\$ 2,237.28	\$ 1,674.00	\$ 1,865.52	\$ 1,216.32	\$ 1,346.40	\$ 1,037.52	\$ 1,146.00
4-18	2,807.64	3,109.56	2,211.00	2,463.00	1,904.76	2,128.68	1,572.48	1,764.00	1,143.96	1,274.04	976.92	1,085.28
19-24	3,629.40	6,178.68	2,880.12	4,959.60	2,502.48	4,358.40	2,163.12	3,819.84	1,548.12	2,675.76	1,323.96	2,261.28
25-29	3,736.08	6,546.96	2,971.56	5,250.84	2,598.84	4,607.52	2,239.44	4,033.68	1,605.60	2,840.76	1,373.04	2,415.84
30-34	4,188.72	6,839.52	3,358.44	5,496.84	2,921.88	4,821.60	2,512.08	4,245.72	1,801.08	3,028.20	1,527.60	2,573.52
35-39	4,898.64	7,669.44	3,981.72	6,231.12	3,457.80	5,469.48	2,996.28	4,807.80	2,136.84	3,433.44	1,829.64	2,921.16
40-44	5,860.68	8,473.92	4,793.16	6,966.36	4,195.32	6,157.80	3,670.68	5,446.92	2,660.52	3,946.68	2,269.32	3,375.36
45-49	7,438.20	9,391.08	6,156.48	7,817.40	5,403.60	6,882.00	4,710.96	6,110.04	3,476.28	4,418.28	2,972.52	3,783.60
50-54	9,697.68	10,680.12	8,090.28	9,018.48	7,074.00	7,938.60	6,167.76	7,064.04	4,542.24	5,131.92	3,879.96	4,404.84
55-59	12,558.12	12,066.84	10,474.08	10,273.80	9,079.80	9,053.28	7,870.44	8,051.40	5,773.68	5,916.60	4,914.48	5,060.64
60-64	15,829.80	13,519.92	13,157.52	11,565.72	11,375.28	10,249.80	9,811.08	9,056.04	7,182.36	6,671.40	6,118.92	5,714.16
65+	17,748.12	14,712.00	14,750.52	12,580.80	12,753.00	11,148.96	10,997.76	9,846.00	8,046.00	7,244.40	6,853.08	6,202.56
1 Child	2,379.96	2,379.96	1,849.20	1,849.20	1,581.96	1,581.96	1,317.48	1,317.48	954.60	954.60	809.76	809.76
2 Children	4,715.28	4,715.28	3,662.40	3,662.40	3,132.72	3,132.72	2,611.80	2,611.80	1,894.44	1,894.44	1,607.52	1,607.52
3+ Children	7,095.24	7,095.24	5,511.60	5,511.60	4,714.68	4,714.68	3,929.28	3,929.28	2,849.16	2,849.16	2,417.16	2,417.16