OKLAHOMA HEALTH INSURANCE HIGH RISK POOL (OHRP) ALTERNATE PLAN

Health Insurance for the Uninsurable. Using PPO Oklahoma for its Provider Network

Provided by the Board of Directors of OHRP

Oklahoma Health Insurance High Risk Pool (OHRP) offers a plan to provide health care benefits for Oklahomans who are MEDICALLY ELIGIBLE or FEDERALLY DEFINED ELIGIBLE.

The program administrators work with the PPO Oklahoma 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 PPO Oklahoma providers, program benefits are reimbursed at a higher percentage.

MEDICAL ELIGIBILITY

Requires a 12 month Residency
Subject to 12 month pre-existing condition exclusion.

Applicants must have applied for health insurance and been rejected by two carriers because of a health condition; OR

Applicants must have been quoted an individual policy rate substantially more than the OHRP rate; OR

Applicants must have been accepted for health insurance subject to an exclusion or waiver of a pre-existing disease or condition (permanent); OR

Applicants have been diagnosed with one of the conditions listed on page 6 of this brochure; AND

Applicant is not eligible for nor covered by health insurance through an employer-sponsored group or self-insured plan or through continuation of such coverage and is not eligible for any other public or private group program that provides or indemnifies for health services
or individual health insurance; AND
Applicant is not eligible for 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).

FEDERALLY DEFINED ELIGIBILITY

Residency Required and MUST apply within 63 Days of Exhaustion of COBRA (if available) or State Continuation Plan

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, government 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 TitleXVIII of the Social Security Act (Medicare) or a State Plan under TitleXIX 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 of 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 provisionor 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
ALTERNATE PLAN

Calendar Year Deductible Amount Options $1,500 $3,000 $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	60% of Allowable Charges in-network, 50% of Allowable Charges out-of-network, and for eligible expenses over $10,000 (after the deductible) the plan pays 80% of Allowable Charges.	40% of Allowable Charges in-network, 50% of Allowable Charges out-of-network, 20% of 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 (the policy will terminate).

BENEFIT CATEGORY 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.	SPECIAL BENEFIT LIMITS OR RESTRICTIONS	Does the deductible apply before this benefit is payable?	Does the regular coinsurance apply to this benefit?	Notes
Outpatient Prescription Drugs Program at network pharmacies and mail order**	$20 Co-pay for generic drugs; $30 Co-pay for Preferred drugs; $50 Co-pay for Non-Preferred drugs***	Generic No Others are Subject to drug Deductible	No	For Preferred and Non-Preferred there is a $500 annual drug deductible
Prostate Cancer Screening	One screen per year for men over 50 (over 40 for high risk) Limited to $65/ screen	No	No	
Mental and Nervous, Alcoholism and Drug Addiction: Inpatient or Outpatient Combined	50% co-payment up to a maximum of $2,000 annually	No	No	
Mammograms	Benefits are limited to $115 per screening. 1 screening per insured age 35 - 39; 1 annual screening per insured age 40 and older.	No	No	

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

*Benefits are payable at the 60% of Allowable Charges level for:
(1) Services provided by PPO Oklahoma network providers and (2) emergency services
Care from non-network providers is payable at 50% of Allowable Charges.

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

***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 (for benefits and full details of coverage including exclusions and limitations, see the Policy)

Hospital Services, Surgical/Medical Services, Outpatient Diagnostic Services (includes mammography screening), Outpatient Therapy Services, 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, 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 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 healing 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 Inpatients Admission, any Outpatient Surgery, Home Health Care Services, Private Duty Nursing, Skilled Nursing, Extended Care, 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 your 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.

Limited Benefits for Treatment of Mental and Nervous Conditions, Alcoholism, and Drug Addiction: Benefits are paid at 50% of Allowable Charges and the maximum benefit for treatment of these conditions is $2,000 per year.

OHRP coverage can be continued for each covered person only while he/she remains an Oklahoma resident.

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 issued to the member when his/her coverage is approved. If a discrepancy occurs between this brochure and the contract, the actual contract is the authority.

Referring agents are not authorized to amend or alter the terms of the OHRP insurance policy, nor are referring agents authorized to bind OHRP in any way.

FOR MORE INFORMATION CALL 1-800-255-6065

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 CONDITIONS and those applying on the basis of FEDERALLY DEFINED ELIGIBILITY must attach different documentation.

MEDICAL CONDITION Documentation

You must provide one of the following documenting 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 page 6 of this brochure, provide a letter of verification from your physician.

If you have been rejected for health care coverage by at least two insurance carriers, include a letter or form from 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 preexisting 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.

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-symptomatic with MI, Polyarteritis Nodosa

Endocrine / Exocrine: Cystic Fibrosis, Diabetes Mellitus, Morbid Obesity

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 granulamatosis, 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, LC. Attention: OHRP P.O. Box 12170, Overland Park, Kansas 66282-2170 1/800 /255-6065.