APPLICATION
AND
PLAN DESCRIPTION

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IOWA COMPREHENSIVE HEALTH ASSOCIATION

Thank you for your interest in the Iowa Comprehensive Health Association (ICHA), also known as Health Insurance Plan of Iowa (HIPIOWA). This comprehensive health insurance plan was created by the Iowa State Legislature to provide access to health insurance coverage to all residents of the state who are denied individual health insurance.

Included in this Packet is an application and information that will explain eligibility, benefits and premiums. Please carefully review all enclosed information.

If you have questions at any time while completing the application, please visit us on-line at www.HIPIOWA.com where you can view additional information or contact our customer service department at 1-877-793-6880. If preferred, prospective insured's may use the assistance of a licensed insurance agent when completing this application.

AGENT INFORMATION

HIPIOWA will pay a $200 fee to Iowa state licensed insurance agents who assist applicants in filling out an approved HIPIOWA application form.

You, as the agent, will need to provide a photocopy of your current insurance license as well as a completed IRS Form W-9. You may download the IRS Form W-9 from the HIPIOWA website (www.HIPIOWA.com) under Agent Information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans such as HIPIOWA and its affiliates to enter into Business Associate Agreements with any service provider or vendors with whom protected health information is shared.

Should you need to assist your clients with any possible issues regarding their account or claims information, it will be necessary that you enter into a Business Associate Agreement with HIPIOWA before we can release to you any protected health information. For example, if you call the Customer Services Department and request information specific to a member or claim, we can not release the information until you have signed the Business Associate Agreement.

You may download a Business Associate Agreement from the HIPIOWA website under Agent Information. Please sign the agreement, make a copy for your records, and return the signed original to the following address:

HIPIOWA
Attention: Privacy Officer
P.O. 1090
Great Bend, KS 67530

The following Agent Information Form must be signed by the agent and returned with the completed application. Please be advised, the information we receive directs the payment of the producer fee to the appropriate entity.

PRODUCER FEE ARRANGEMENT

If Application is being made through a producer, he / she must provide the information below.

PLEASE NOTE: The information provided on this form will direct the payment of the producer fee to the appropriate entity

<table>
<tr><td colspan="2">Agent Name</td><td colspan="2">Firm or Agency</td></tr>
<tr><td colspan="2">Agent or Agency Address</td><td colspan="2">Telephone Number</td></tr>
<tr><td>Agent’s Insurance License No.</td><td colspan="2">☐ Copy of License Attached
☐ Copy of License Already on File</td><td>Expiration Date</td></tr>
<tr><td>Agent or Agency Tax ID Number</td><td colspan="2">☐ Copy of IRS Form W-9 Attached
☐ Copy of IRS Form W-9 Already on File</td><td>Contact Person</td></tr>
</table>

HOW TO CONTACT US

ON THE WEB:
www.HIPIOWA.com

BY PHONE:
1.877.793.6880

BY FAX:
1.620-793-1199

VIA MAIL:
HIPIOWA
P.O. Box 1090
Great Bend, KS 67530

ADMINISTERED BY:
Benefit Management, Inc (BMI)

GENERAL ELIGIBILITY REQUIREMENTS

Coverage is available to persons who meet the following general requirements:

1. You must also meet one of the Eligibility Categories listed below.

2. If you are applying under Medical Eligibility, or Medical Condition Eligibility, You must be a resident of the Sate of Iowa – "resident" means a person who has been legally domiciled in the state of Iowa for a period of at least 60 days for purposes other than obtaining insurance. Domicile denotes a person's permanent home and place of habitation. You mist attach evidence of residency with this application.

3. If you are a HIPAA Eligible Individual, TAA Eligible Individual or you are coming from a Basic and Standard Plan, You must be a resident of the State of Iowa, although you are not required to satisfy the 60 day time from nor are you required to attach evidence of residency with this application.

MEDICAL ELIGIBILITY (At least one of the following must apply to be considered under the Medical Eligibility guidelines)

a. A notice of rejection of health insurance coverage within the last nine months.

b. A notice of health insurance benefit reduction or limitation which substantially reduces benefits compared to benefits available to others such as a rider which excludes or modifies benefits for a condition.

c. A notice of refusal to issue insurance except at a rate exceeding the plan rate of a comparable HIPIOWA plan.

d. Other involuntary termination (other than non-payment)

MEDICAL CONDITION

If you have been a legal resident of the State of Iowa for the past 60 days and you suffer from one of the following, you are eligible under the Medical Condition.

- Acquired Immune Deficiency Syndrome (AIDS)
- Angina Pectoris

- Arteriosclerosis Obliterans
- Artificial Heart Valve
- Ascite
- Cardiomyopathy
- Chemical Dependency
- Cirrhosis of the Liver
- Coronary Insufficiency
- Coronary Occlusion
- Cystic Fibrosis
- Dermatomyositis
- Friedrich's Disease
- Huntington's Disease
- Hydrocephalus
- Intermittent Claudication
- Juvenile Diabetes
- Kidney Failure requiring dialysis
- Lead Poisoning with Cerebral Involvement
- Leukemia
- Lupus
- Malignant Tumor (if treated or has occurred within last four years)
- Metastatic Cancer
- Motor or Sensory Aphasia
- Multiple or Disseminated Sclerosis
- Muscular Atrophy or Dystrophy
- Myasthenia Gravis
- Myotonia
- Open Heart Surgery
- Paraplegia or Quadriplegia
- Parkinson's Disease
- Peripheral Arteriosclerosis (if treatment within last three years)
- Polyarteritis (periarteritis nodosa)
- Postero-lateraol Sclerosis
- Psychotic Disorders
- Silicosis
- Splenic Anemia (True Banti's Syndrome)
- Still's Disease
- Stroke
- Syringomyelia Tabes Dorsalis (locomotor ataxia)
- Topectomy and Lobotomy
- Wilson's Disease

FEDERAL ELIGIBILITY

a. HIPAA Eligible Individual--You must be defined as an "Eligible Individual" according to the Health Insurance Portability and Accountability Act, meaning that you:

    1. Must have had 18 months or more of creditable coverage without a break of 63 full days prior to applying for this plan;

2. Must have had the most recent prior creditable coverage under a group health plan, governmental plan or church plan (or under health insurance coverage offered in connection with such a plan);

3. May not be eligible for a group health plan;

4. May not be eligible for Medicare or Medicaid;

5. Must not have lost the most recent coverage because of fraud or non-payment of premiums;

6. If offered COBRA or a similar state program, must elect and exhaust such coverage

b. Federal Trade Act Eligible Individual

1. Must be able to provide supporting documentation of eligibility.

BASIC AND STANDARD ELIGIBILITY

You are eligible if you are a current Basic and Standard Policy Holder.

NOT ELIGIBLE FOR HIPIOWA COVERAGE

You are not eligible if you meet any of the criteria listed below:

1. You are not a resident of the State of Iowa.

2. You have terminated coverage in HIPIOWA within the last 12 months, unless you can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums; (This does not apply to HIPAA Eligible or TAA Eligible Individuals)

3. You are an inmate of a public institution; (This does not apply to HIPAA Eligible or TAA Eligible Individuals)

4. You have been paid the maximum allowable benefits payable under this program: or

5. You are eligible for a group plan through an employer; or

6. You are eligible for public programs for which the individual premiums are paid for or reimbursed under any government sponsored program or by any government or health care provider.

7. You are eligible for health care benefits under Chapter 249A of the Iowa Code (Medicaid).

HOW TO APPLY TO HIPIOWA

MEDICAL ELIGIBILITY

- If you have been rejected for coverage by an insurance carrier within the last nine months because of health status, you must attach a copy of the rejection notice provided by that carrier.
- If you have received a notice of a health insurance benefit reduction or limitation which substantially reduces benefits compared to benefits available to others, such as a rider which excludes or modifies benefits for a condition, you must attach a copy of the notice provided by that carrier.
- If you have received a notice of refusal to issue insurance except at a rate exceeding the plan rate of a comparable ICHA plan, you must attach a copy of the notice.
- For any involuntary terminations, you must attach verification of the termination. This would not include termination due to non-payment.

MEDICAL CONDITION

- If you have one of the listed health conditions, check all that apply.

FEDERAL ELIGIBILITY

- If you qualify under the federal eligibility guidelines, you will need to provide a certificate of coverage with the application or as soon as you receive it from your prior carrier(s). If you do not have a certificate of coverage, you may provide other documentation that demonstrates prior coverage beginning **and** ending dates.
- If you are eligible for the Federal Trade Act, you must provide supporting documentation.

BASIC AND STANDARD ELIGIBILITY

- If you currently have Iowa Basic & Standard health coverage, you will need to provide your policy information on the application.

Applications postmarked on or before the 20th day of the month will be effective on the first day of the following month.

Applications postmarked after the 20th day of the month will be effective on the first day of the second month following receipt.

Under limited circumstances, an ICHA applicant may choose to have the effective date of coverage retroactive to an earlier date. In order for this opportunity to apply, the applicant must first apply for coverage and be rejected by a health insurance carrier licensed in the State of Iowa. If the applicant then applies to ICHA no later than the end of the full calendar month following the date of original application to the health carrier, the ICHA applicant may choose the first of the month of the ICHA application as the effective date for coverage.

Once your application is approved, we will send you an identification card, insurance policy and a provider directory. The insurance policy provides specific details of your plan's benefits and

the procedures you need to follow in order to get the maximum benefits to which you are entitled.

PLAN OPTIONS

HIPIOWA offers five comprehensive preferred provider plans to choose from as well as a Medicare carveout plan.

- PLAN E is a Medicare eligible plan for persons **under** 65 that are enrolled in Medicare. The plan pays secondary to Medicare and has an annual deductible of $1000. If you are eligible for Medicare because you have reached age 65, you are not eligible for this or any other HIPIOWA plan.

- PLANS B, C, D, F AND G are preferred provider plans. These plans give you the option of choosing any provider but pay at a higher percentage of allowed charges if you choose a provider who is part of the Midlands Choice Network. They offer a $1,000, $1,500, $2,500, $5,000 and $10,000 deductible. These plans are not available to Medicare eligible enrollees.

Check with your medical providers for their participation in the Midlands Choice Network or call Midlands Choice at 1.800.605.8259 prompt #5, to verify if your health care provider participates in the network. You can also review the Midlands Choice Provider network through the HIPIOWA web page @ www.HIPIOWA.com. A copy of the Midlands Choice Provider directory is also available on request. (All plan enrollees receive a directory with their medical plan contract document.)

- A Pharmacy Benefit is included on all preferred provider plans and gives you access to a nationwide network of pharmacies. By using the pharmacy network you will benefit from negotiated discounts on prescription drugs (upon presentation of your identification card). All drugs, supplies, medicines and pharmacy services must be obtained at a network pharmacy. Pharmacy services for Plans F and G are subject to a separate pharmacy deductible. Pharmacy services for Plans B, C and D are not subject to a separate pharmacy deductible or the annual deductible, instead they require a per prescription copayment. The pharmacy benefit has an out-of-pocket expense limit separate from the medical out-of-pocket expense limit. **Please Note:** There is **no** pharmacy benefit for Plan E, the Medicare Carveout Plan.

SUMMARY OF BENEFITS

The following pages are a brief summary of your Plan benefits. Benefits are subject to the full description, provisions, limitations and exclusions set out in the HIPIOWA Plan Policy, which is a complete Plan contract issued to You at the time of Your enrollment. Plan Policy documents are available for review on the HIPIOWA web site and are also available upon request to HIPIOWA. In the event of a discrepancy between this summary and the HIPIOWA Plan Policy, the HIPIOWA Plan Policy will govern.

Iowa Comprehensive Health Association (ICHA)
Outline of Benefit Plans

This document is intended for descriptive purposes only.
All benefits are subject to the terms, conditions, limitations, exclusions, deductibles, copayments, and any and all other contract provisons.
Actual contract provisions prevail in the event of conflict with this document.

Feature / Benefit	HIPIOWA PLANS				
	Plan B - $1000 Deductible	**Plan C - $1500 Deductible**	**Plan D - $2500 Deductible**	**Plan F - $5000 Deductible**	**Plan G - $10,00 Deductible**
Coinsurance (In-Network / Out-of-Network)	80% / 60%	80% / 60%	80% / 60%	80% / 60%	100% / 80%
Deductible (In-Network / Out-of-Network)	$1,000/$2,000	$1,500/$3,000	$2,500/$5,000	$5,000/ $10,000	$10,000/$20,000
Stop Loss Limit (Coinsurance Maximum) (In-Network / Out-of-Network)	$7,500/$7,500	$7,500/$7,500	$12,500/$12,500	$12,500/$12,500	- / $12,500
Out-of-Pocket Maximum (OOP) (In-Network / Out-of-Network)* *OOP includes Deductible & Coinsurance	$2,500/$5,000	$3,000/$6,000	$5,000/$10,000	$7,500/$15,000	$10,000/$22,500
Lifetime Maximum Benefit	$3 million				
Deductible Carryover Provision	Yes, deductible carryover of expenses in last 90 days of CY				
Pre-Existing Conditions	6 months prior / coverage excluded for 6 months after effective date of policy				
Covered Benefits Eligible expenses are payable for the following benefits, and are subject to the deductible and coinsurance unless otherwise noted. Certain benefits may be subject to inside limits as noted.					
Inpatient Medical / Surgical Services					
Hospital room & board [1]	Covered, no limit				
General nursing care	Covered				
Medical and surgical supplies	Covered				
Accidental injury care	Covered				
Hospital intensive care units (including cardiac care etc.)	Covered				
Inpatient physician and professional services	Covered				
Anesthetics and their administration	Covered				
Diagnostic services - lab, X-ray, MRI, electrocardiogram, etc.	Covered				
Chemotherapy and hemodialysis services	Covered				
Drugs and biologicals	Covered				
Dressings and casts	Covered				
Intravenous injections and solutions	Covered				
Skilled Nursing Facility (SNF)	Covered. Covered expenses limited to semi-private room charge with maximum 60 days benefit/CY. Pre-certification required.				
Short-Term Inpatient Physical Rehabilitation (facility charges and physician/professional services)					
Physical Therapy	Covered				
Occupational Therapy	Covered				
Speech Therapy	Covered				
Cardiac Rehabilitation	Covered				
Pulmonary Rehabilitation	Covered				
Emergency care	Covered				
Outpatient Medical / Surgical Services					
Doctor's office visits & related expenses, consultations, medical treatments, office surgery	$20 copay/visit in-network	$30 copay/visit in-network	$40 copay/visit in-network	Subject to deductible and coinsurance	Subject to deductible and coinsurance
	Office visit only. Other services subject to deductible and coinsurance. Out of network subject to deductible and coinsurance.				
Allergy testing and treatment including allergy injections, therapeutic injections	Covered				
Outpatient facility charges (hospital, ambulatory surgical center)	Covered				
Outpatient physician and professional services	Covered				
Medical and surgical supplies	Covered				
Accidental injury care	Covered				
Anesthetics and their administration	Covered				
Diagnostic services - lab, X-ray, MRI, electrocardiogram, etc.	Covered				
Chemotherapy and hemodialysis services	Covered				
Drugs and biologicals	Covered				
Dressings and casts	Covered				
Intravenous injections and solutions	Covered				
Outpatient Physical Rehabilitation (facility charges and physician/professional services) Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Pulmonary Rehabilitation	Covered subject to pre certification. Subject to deductible and coinsurance.				
Emergency care	$100 copay. Waived if admitted.				
Urgent care facility	$75 copay				
Mental Health and Chemical Dependency Services					
Mental Health	MHCD combined benefits - In network covg only - subject to deductible and coinsurance.				

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	Plan B - $1000 Deductible	**Plan C - $1500 Deductible**	**Plan D - $2500 Deductible**	**Plan F - $5000 Deductible**	**Plan G - $10,00 Deductible**
Inpatient	Limited to 20 days/year; combined with CD				
Outpatient	Limited to 45 visits/year, combined with CD.				
Chemical dependency (Alcoholism, Substance Abuse)					
Inpatient	Limited to 20 days/year, combined with MH.				
Outpatient	Limited to 45 visits/year, combined with MH.				
Preventive Services					
Well-child care including physical exams, immunizations, and lab	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.				
Adult routine physical	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.				
Routine pap smear					
Routine mammogram					
Prostatic specific antigen (PSA) tests					
Lead screening					
Prescription Drugs	Rx copays do NOT apply to OOP max. Mail order copays = 2x retail.				
Prescription Drugs	Drug card with copay = greater of $10/$30/$50 or 25% for all plans, with $1,000 maximum drug out-of-pocket limit per calendar year. Copay is actual cost of drug if less than computed copay.				
	No separate drug deductible			Separate $500 Rx deductible	Separate $1,000 Rx deductible
	Restricted (brand copay when generic is available = generic copay $10 plus difference in cost between brand and generic).				
Outpatient Contraceptive Services, including prescription drugs/devices	Covered.				
Transplants					
Transplants	Covered, subject to standard limits of plan, but required to receive treatment at "in-network" facility (i.e., centers of excellence, etc.)				
Types of organ or tissue transplants covered: Cornea Heart Heart-lung Kidney Kidney-pancreas Pancreas Liver Liver-pancreas Bone marrow Single lung transplants Double lung transplants Small bowel	Those certified as medically necessary (any transplants not considered experimental are covered).				
Donor-related expenses	Donor-related expenses for surgery and physician visits are covered to same extent benefits available under the policy.				
Transportation/lodging	Not covered				
Maternity					
Complications of pregnancy	Covered				
Routine maternity care, including delivery room, pre-natal and post-natal care	Optional Rider, pays up to $5000 covered expenses for normal pregnancy and childbirth including routine hospital and nursing services for newborn child during mother's confinement. Not subject to policy's deductible or coinsurance provisions.				
Other Covered Services					
Ambulance Services (air or ground)	Covered				
Home Health Care	40 visits per calendar year.				
Hospice Care	Covered. Counseling for immediate family covered subject to 90 days per family, bereavement counseling for immediate family covered subject to $250 maximum.				
Durable Medical Equipment (DME)	Covered (no limit, must be medically necessary, subject to prior approval)				
Blood administration; oxygen	Covered				
Oxygen and equipment	Covered				
Prosthetic appliances	Covered				
Oral surgery for certain services	Covered				
Home infusion therapy	Covered				
Private duty nursing	Not covered				
Chiropractic care	Subject to rehabilitation limits. Maximum of 15 visits per calander year. Requires precertification.				
Infertility treatment	Not covered				
Temporomandibular joint syndrome	$1000 lifetime maximum				
Tubal ligation or vasectomy	Covered				
Dental Treatment for Injury	Covered				
Breast reconstruction after mastectomy surgery	Covered				
Diabetes treatment	Covered				
Diabetes education	Diabetes education program expenses covered at 80% (not subject to deductible).				
Growth therapy treatment	Not covered.				
Services Not Covered					
Sex transformations, penile implants, complications	Not covered				

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Feature / Benefit	HIPIOWA PLANS				
	Plan B - $1000 Deductible	**Plan C - $1500 Deductible**	**Plan D - $2500 Deductible**	**Plan F - $5000 Deductible**	**Plan G - $10,00 Deductible**
Infertility treatment	Not covered				
Sterilization	Covered				
Dental care, surgery, or treatment (except reconstructive surgery due to covered injury is covered)	Not covered				
TMJ or surgery of the jaw except as above	Not covered				
Family planning visits	Not covered				
Nutrition counseling	Not covered				
Routine vision exams	Not covered				
Routine hearing exams	Not covered				
Cosmetic surgery or complications; breast augmentation or reduction	Not covered				
Weight modification; treatment of obesity	Not covered				
Eyeglasses, hearing aids, related exams	Not covered				
Orthopedic shoes, foot inserts, support devices for feet, etc.	Not covered				
Convalescent, rest, or nursing facility care except as provided	Not covered				
Experimental or investigative services, supplies, treatments	Not covered				
Private duty nursing, except for covered HHC or Hospice Care	Not covered				
Acupuncture	Not covered				
Smoking cessation classes	Not covered				
Custodial care expenses	Not covered				
Routine podiatry (treatment of feet)	Not covered				
Biofeedback	Not covered				
Massage therapy	Not covered				
Behavior modification and learning disabilities	Not covered				
Alternative medicine	Not covered				

Footnotes
[1] Semi-private or private if medically necessary

HIPIOWA
Iowa Comprehensive Health Association

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Feature / Benefit	**HIPIOWA Carveout Plan** Plan E Medicare Carveout $1000 Deductible
Coinsurance	80%
Deductible	$1,000
Stop Loss Limit (Coinsurance Maximum)	$7,500
Out-of-Pocket Maximum (OOP)* *OOP includes Deductible & Coinsurance	$2,500
Lifetime Maximum Benefit	$3 million
Benefit Year Definition	Calendar Year (CY)
Deductible Carryover Provision	Yes, deductible carryover of expenses in last 90 days of CY.
Pre-Existing Conditions	6 months prior / coverage excluded for 6 months after effective date of policy.
Covered Benefits Eligible expenses are payable for the following benefits, and are subject to the deductible and coinsurance unless otherwise noted. Certain benefits may be subject to inside limits as noted.	
Inpatient Medical / Surgical Services	
Hospital room & board [1]	Covered, no limit.
General nursing care	Covered
Medical and surgical supplies	Covered
Accidental injury care	Covered
Hospital intensive care units (including cardiac care et	Covered
Inpatient physician and professional services	Covered
Anesthetics and their administration	Covered
Diagnostic services - lab, X-ray, MRI,	Covered
Chemotherapy and hemodialysis services	Covered
Drugs and biologicals	Covered
Dressings and casts	Covered
Intravenous injections and solutions	Covered
Skilled Nursing Facility (SNF)	Covered. Covered expenses limited to semi-private room charge with maximum 60 days benefit/CY. Pre-certification required.
Short-Term Inpatient Physical Rehabilitation (facility charges and physician/professional services) Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Pulmonary Rehabilitation	 Covered Covered Covered Covered Covered
Emergency care	Covered
Outpatient Medical / Surgical Services	
Doctor's office visits & related expenses, consultations, medical treatments, office surgery	No Copay [2]
	Office visit only. Other services subject to deductible and coinsurance. Out of network subject to deductible and coinsurance.
Allergy treatment including allergy injections,	Covered
Outpatient facility charges (hospital, ambulatory	Covered
Outpatient physician and professional services	Covered
Medical and surgical supplies	Covered
Accidental injury care	Covered
Anesthetics and their administration	Covered
Diagnostic services - lab, X-ray, MRI,	Covered
Chemotherapy and hemodialysis services	Covered
Drugs and biologicals	Covered
Dressings and casts	Covered
Intravenous injections and solutions	Covered
Outpatient Physical Rehabilitation (facility charges and physician/professional services) Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Pulmonary Rehabilitation	 Covered subject to case management and limit of 15 visits/CY. Subject to deductible and coinsurance.
Emergency care	No Copay [3]
Urgent care facility	No Copay [3]

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Feature / Benefit	**HIPIOWA Carveout Plan** Plan E Medicare Carveout $1000 Deductible
Mental Health and Chemical Dependency Services (MHCD)	
Mental Health (MH)	MHCD combined benefits - In network coverage only - subject to deductible and coinsurance.
Inpatient	Limited to 20 days/year; combined with CD.
Outpatient	Limited to 45 visits/year, combined with CD.
Chemical Dependency (CD) (Alcoholism, Substance Abuse)	
Inpatient	Limited to 20 days/year, combined with MH.
Outpatient	Limited to 45 visits/year, combined with MH.
Preventive Services	
Well-child care including physical exams, immunizations, and lab services	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.
Adult routine physical	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.
Routine pap smear	
Routine mammogram	
Prostatic specific antigen (PSA) tests	
Lead screening	
Prescription Drugs	
Prescription Drugs	Not Covered Unless Covered by Medicare
Transplants	
Transplants	Covered, subject to standard limits of plan, but required to receive treatment at "in-network" facility (i.e., centers of excellence, etc.).
Types of organ or tissue transplants covered: Cornea Heart Heart-lung Kidney Kidney-pancreas Pancreas Liver Liver-pancreas Bone marrow Single lung transplants Double lung transplants Small bowel	Those certified as medically necessary (any transplants not considered experimental are covered).
Donor-related expenses	Donor-related expenses for surgery and physician visits are covered to same extent benefits available under the policy.
Maternity	
Complications of pregnancy	Covered
Routine maternity care, including delivery room, pre-natal and post-natal care	Optional Rider, pays up to $5000 covered expenses for normal pregnancy and childbirth including routine hospital and nursing services for newborn child during mother's confinement. Not subject to policy's deductible or coinsurance provisions.

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Feature / Benefit	**HIPIOWA Carveout Plan** Plan E Medicare Carveout $1000 Deductible
Other Covered Services	
Ambulance Services (air or ground)	Covered
Home Health Care	Covered, 40 visits per calendar year.
Hospice Care	Covered. Counseling for immediate family covered subject to 90 visits per family, bereavement counseling for immediate family covered subject to $250 maximum.
Durable Medical Equipment (DME)	Covered (no limit, must be medically necessary, subject to prior approval).
Blood administration; oxygen	Covered
Oxygen and equipment	Covered
Prosthetic appliances	Covered
Oral surgery for certain services	Covered
Home infusion therapy	Covered
Chiropractic care	Subject to rehabilitation limits.
Temporomandibular joint syndrome	Covered with a $1000 lifetime maximum.
Tubal ligation or vasectomy	Covered
Dental Treatment for Injury	Covered
Breast reconstruction after mastectomy surgery	Covered
Diabetes treatment	Covered
Diabetes education	Diabetes education program expenses covered. Subject to coinsurance. Not subject to deductible.
Services Not Covered	
Sex transformations, penile implants, complications	Not covered
Infertility treatment	Not covered
Dental care, surgery, or treatment (except reconstructive surgery due to covered injury)	Not covered
TMJ or surgery of the jaw except as above	Not covered
Family planning visits	Not covered
Nutrition counseling	Not covered
Routine vision exams	Not covered
Routine hearing exams	Not covered
Cosmetic surgery or complications; breast augmentation or reduction	Not covered
Weight modification; treatment of obesity	Not covered
Eyeglasses, hearing aids, related exams	Not covered
Orthopedic shoes, foot inserts, support devices for	Not covered
Convalescent, rest, or nursing facility care except as provided above	Not covered
Experimental or investigative services, supplies,	Not covered
Private duty nursing, except for covered HHC or	Not covered
Acupuncture	Not covered
Smoking cessation classes	Not covered
Custodial care expenses	Not covered
Routine podiatry (treatment of feet)	Not covered
Biofeedback	Not covered
Massage therapy	Not covered
Behavior modification and learning disabilities	Not covered
Growth therapy treatment	Not covered.
Private duty nursing	Not covered
Infertility treatment	Not covered
Transportation/lodging	Not covered
Alternative medicine	Not covered

Footnotes

[1] Semi-private or private if medically necessary

[2] $20 copay applies when the service is not covered by Medicare

[3] $100 copay applies when the service is not covered by Medicare

HIPIOWA
Iowa Comprehensive Health Association

APPLICATION CHECKLIST

☐ Did you choose a health care plan? **Please Note:** Changing plans can only be done effective January 1st each year. Once you have selected a deductible plan, a lower deductible cannot be chosen at a later date. If you are eligible for Medicare, you must choose Plan E. **See section I of the application.**

☐ If you plan on including maternity benefits as part of you plan, did you select the optional Maternity Rider? **Please Note:** The Maternity Rider is only available at the time of your initial enrollment. This rider cannot be added at a later date. **See section I of the application.**

☐ Have you included proof of Iowa residency? **See Section II of the application.**

☐ Did you check an eligibility category? Did you include a copy of the documentation asked for under the category you checked? **See Section III of the application.**

☐ Did you identify any other health care coverage in effect? **See section IV of the application.**

☐ If you had prior creditable coverage, did you include a copy of your Certificate of Coverage or other proof of coverage? **See Section V of the application.**

☐ If you plan to allow others to access your personal health information, did you complete, sign and enclose the Personal Representative Form?

☐ Did you identify a premium payment cycle (Monthly Bank Draft, Quarterly, Semi-Annual or Annual)? **See Section VI of the application.**

☐ Have you included the premium payment due according to the payment cycle chosen? **See the Rate Table and Section VI of the application?**

☐ If you chose the Monthly Bank Draft premium payment cycle, did you include one month's premium? Did you complete, sign and enclose the Authorization Agreement for Automatic Withdrawal? Did you attach a voided check?

☐ Did you date and sign the Application? **See section VII.**

If you have any questions about any of the above information or completing the application, please contact our customer service department at 1.877.793.6880.

HIPIOWA
Iowa Comprehensive
Health Association

APPLICATION FOR COVERAGE

SECTION I: PLAN INFORMATION

Please select your Plan Deductible. Changing plans can only be done effective January 1st each year. Once your Plan is selected, you may only change to a higher deductible Plan.

Plans

- ☐ E - $1,000 Deductible - **Medicare Only**
- ☐ B - $1,000 Deductible
- ☐ C - $1,500 Deductible
- ☐ D - $2,500 Deductible
- ☐ F - $5,000 Deductible
- ☐ G - $10,000 Deductible

Rider

- ☐ Optional Maternity Rider

SECTION II: APPLICANT INFORMATION

Name & Personal Information

Last Name:_____ First Name:_____ MI:_____

Soc. Sec. No.:_____ DOB(mm/dd/yy):_____ Age:____ ☐ Male ☐ Female

Custodial Parent/Guardian Name, if applicant is a minor or not legally competent:

_____

Address & Phone

Street Address (required):_____

City:_____ State:_____County:_____ Zip Code:_____

P.O. Box (optional):_____City:_____ State:_____ Zip Code:_____

Home Phone:_____Business Phone:_____

Billing Address & Name of entity or person responsible for payment, if different from above:

_____

Residency. "Resident" means a person who has been legally domiciled in this state **for a period of at least 60 days** for purposes other than obtaining insurance.

I have been a resident of Iowa continuously since:_____. You must attach one of the following as proof of residency with this application:

(a) A bill in your name from any public utility at your dwelling in the State of Iowa;
(b) Receipts for rent, mortgage or lease payments for your dwelling in Iowa;
(c) An Iowa driver's license or state identification card;
(d) Proof of registration and payment in Iowa of taxes and fees on motor vehicles;
(e) A voter registration card; or
(f) A copy of your State of Iowa Tax Return.

SECTION III: ELIGIBILITY

A. Eligibility Requirements

I certify, as indicated below, that I am eligible for coverage because:

☐ 1. **Federal Eligibility.**

a. HIPAA Eligible Individual**. (All of the following must apply to be considered under the Federal Eligibility guidelines)**. Please provide a copy of your Certificate of Creditable Coverage or other proof of such coverage.

I am a current resident of the State of Iowa and all of the following apply:

- ☐ I have had 18 months of continuous creditable coverage during which I have not had a break in coverage of 63 or more complete days in a row, at least the last day of which was under a group health plan.
- ☐ I was not terminated based upon nonpayment of premiums or fraud in respect to my most recent coverage.
- ☐ I have used up any COBRA or state continuation of coverage for which I was eligible.
- ☐ I am not eligible for Medicare, Medicaid or a group health plan.
- ☐ I do not have other health insurance coverage.

b. Federal Trade Act Eligible Individual. I am a current resident of the State of Iowa and:

- ☐ I have been declared by the federal government to be a Federal Trade Act Eligible Individual. I have attached the documentation provided to me by the federal government evidencing my eligibility as a Federal Trade Act Eligible Individual.

☐ 2. **Basic & Standard Eligibility.** I am a current resident of the State of Iowa and:

- ☐ I currently have Iowa Basic & Standard health coverage.

☐ 3. **Medical Eligibility.** (At least **one** of the below must apply to be considered under the Medical Eligibility guidelines. **INSURANCE COMPANY NOTICE OF REJECTION OR TERMINATION OF HEALTH INSURANCE MUST BE ATTACHED.**)

I am a legal resident of the State of Iowa for the past 60 days and at least **one** of the below applies:

- ☐ A notice of rejection of health insurance coverage within the last nine months.
- ☐ A notice of health insurance benefit reduction or limitation which substantially reduces benefits compared to benefits available to others such as a rider which excludes or modifies benefits for a condition.
- ☐ A notice of refusal to issue insurance except at a rate exceeding the plan rate of a comparable ICHA plan.
- ☐ Other involuntary termination (other than non-payment).

☐ 4. **Medical Condition Eligibility.** I am a legal resident of the State of Iowa for the past 60 days and suffer from the below listed health condition(s). Please check all that apply.

❑ Acquired Immune Deficiency Syndrome (AIDS)	❑ Kidney Failure requiring dialysis	❑ Polyarteritis (periarteritis nodosa)
❑ Angina Pectoris	❑ Lead Poisoning with Cerebral Involvement	❑ Postero-lateraol Sclerosis
❑ Arteriosclerosis Obliterans	❑ Leukemia	❑ Psychotic Disorders
❑ Artificial Heart Valve	❑ Lupus	❑ Silicosis
❑ Ascite	❑ Malignant Tumor (if treated or has occurred within last four years)	❑ Splenic Anemia (True Banti's Syndrome)
❑ Cardiomyopathy	❑ Metastatic Cancer	❑ Still's Disease
❑ Chemical Dependency	❑ Motor or Sensory Aphasia	❑ Stroke
❑ Cirrhosis of the Liver	❑ Multiple or Disseminated Sclerosis	❑ Syringomyelia Tabes Dorsalis (locomotor ataxia)
❑ Coronary Insufficiency	❑ Muscular Atrophy or Dystrophy	❑ Topectomy and Lobotomy
❑ Coronary Occlusion	❑ Myasthenia Gravis	❑ Wilson's Disease
❑ Cystic Fibrosis	❑ Myotonia	
❑ Dermatomyositis	❑ Open Heart Surgery	
❑ Friedrich's Disease	❑ Paraplegia or Quadriplegia	
❑ Huntington's Disease	❑ Parkinson's Disease	
❑ Hydrocephalus	❑ Peripheral Arteriosclerosis (if treatment within last three years)	
❑ Intermittent Claudication		
❑ Juvenile Diabetes		

NO PERSON IS ELIGIBLE FOR COVERAGE IF ONE OF THE FOLLOWING APPLIES:

1. Residency requirements are not met.
2. The person is eligible for health care benefits under Chapter 249A of the Iowa Code (Medicaid).
3. The person has terminated coverage with ICHA within the last 12 months (this requirement does not apply to federally eligible individuals).
4. The person is an inmate of a public institution.
5. The person is eligible for public programs for which the individual premiums are paid for or reimbursed under any government sponsored program or by any government agency or care provider.
6. The person has already received the maximum allowable benefits payable under this program.
7. The person is or becomes eligible for group coverage.
8. The person is eligible to elect COBRA or state continuation coverage.

B. Other Eligibility Information

1. Have you ever been enrolled in ICHA? Yes ☐ No ☐

2. For persons applying for ICHA Plan A ($1,000 Deductible-Medicare Only), I understand that this plan is designed for persons enrolled in Parts A and B of the Federal Medicare Program. My Medicare health insurance number is _____.
   I additionally understand that if I am not enrolled in Part B of the Federal Medicare Program, the amount that is payable under ICHA Plan A will be calculated as if I were enrolled in Medicare Part B.

3. Medicare Eligibility
   Are you currently eligible for Medicare based upon age? Yes ☐ No ☐
   Are you currently eligible for Medicare due to disability? Yes ☐ No ☐

SECTION IV: OTHER COVERAGE

This coverage will pay secondary to any other coverage unless pre-empted by federal law.

1. Do you have any other medical or hospital insurance? (Please list on separate page if additional space is necessary.)
   ☐ Yes ☐ No Medical Assistance (Medicaid/Title 19).
   ☐ Yes ☐ No Aid to Families with Dependent Children.
   ☐ Yes ☐ No Supplemental Security Income.
   ☐ Yes ☐ No Iowa Basic or Standard Coverage.

   Other Coverage 1:

   _____
   (Last Name) (First Name) (MI) (Description of Coverage - Indiv. or Group)

   _____
   (Insurance Co. Name & Phone No.) (Policy No.)

   Other Coverage 2:

   _____
   (Last Name) (First Name) (MI) (Description of Coverage - Indiv. or Group)

   _____
   (Insurance Co. Name & Phone No.) (Policy No.)

2. Do you intend to allow to lapse or otherwise terminate your present policy and replace it with ICHA coverage? ☐ Yes ☐ No If yes, dated terminated: _____.

SECTION V: PREEXISTING CONDITIONS

ICHA plans have a six-month waiting period for preexisting conditions. This means that preexisting conditions will not be covered until the ICHA policy has been in force for six months. Preexisting conditions are conditions which medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for shortening the preexisting condition waiting period, please complete the following information **and attach your Certificate of Coverage from your current or prior carrier.** If you do not have a Certificate of Coverage, you may provide other evidence (including a telephone call from the plan or issuer) that demonstrates prior coverage beginning and ending dates.

1. Please list below your current or prior coverage information:

   _____
   Name & Telephone No. of Carrier [Insurance Company])

   _____
   (Name & ID No. of Subscriber [Contract Holder])

   Date coverage began:_____Date coverage ended:_____

   Per Indiv. Deductible Amount $_____Out-of-pocket Max. Amount $_____

   Family Deductible Amount $_____Out-of-pocket Max. Amount $_____

   Type of Coverage: ☐ Individual ☐ Group ☐ Basic or Standard Coverage
   Type of Benefits (check all that apply): ☐ Medical ☐ Hospital Only ☐ Accident Only
   ☐ Prescription Drug ☐ Dental Vision

2. Do you intend to continue this other coverage if you are accepted for coverage by ICHA?
   ☐ Yes ☐ No If no, you must contact your insurance company to cancel.

The preexisting condition waiting period will be reduced or waived in the following circumstances:

- Federally defined eligible individuals. We will waive the preexisting condition wait for any person who is eligible for such waiver under the standards of the Federal Health Insurance Portability and Accountability Act. This includes persons who are Federal Trade Act eligible individuals.

- Individuals with prior creditable coverage whose coverage was involuntarily terminated and who are not federally defined eligible individuals. Applicants will receive a waiver of preexisting condition exclusions to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated if:
  (a) application is made to ICHA within 63 days of termination of that previous plan; and
  (b) the applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to the plan coverage.

- Individuals with prior individual comprehensive major medical coverage whose prior coverage was or will be voluntarily terminated. Applicants will receive a waiver of preexisting condition exclusions if:
  (a) the prior coverage is voluntarily terminated individual comprehensive major medical coverage;
  (b) there has been 18 months of continuous prior individual comprehensive major medical coverage;
  (c) application is made to ICHA within 63 days of termination of the individual comprehensive major medical coverage; and
  (d) the applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to the plan coverage.

- Basic and Standard Prior Coverage. Applicants transferring to a ICHA policy from a basic or standard health benefit plan under Chapter 513C beginning on or after January 1, 2005, will receive a pre-existing condition waiver.

- Eligible Newborns with prior creditable coverage. In the case of an eligible individual who, as of the last day of the thirty-one day period beginning with the date of birth, is covered under creditable coverage.

SECTION VI: PREMIUM PAYMENT

[PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:]
[☐ **MONTHLY BANK DRAFT** - 1 month premium due with application.]
(Complete attached Authorization Form and include a VOIDED check.)]
[☐ **QUARTERLY** - 3 months premium due with application.]
[☐ **SEMI-ANNUAL** - 6 months premium due with application.]
[☐ **ANNUAL** - 12 months premium due with application.]

MAKE CHECK PAYABLE TO ICHA

[USE THE RATE TABLE TO DETERMINE YOUR PREMIUM PAYMENT.]

[Premium Rate Table used: _____]

[

PREMIUM AMOUNT (ACCORDING TO YOUR PAYMENT OPTION):
PREMIUM AMOUNT ENCLOSED:

FOR OFFICE USE ONLY	
PREMIUM PAYMENT	CHECK NUMBER

]

EFFECTIVE DATE OF COVERAGE:
NOTE: Approved applications are effective the first of the month as follows:

- Applications postmarked by the 20th day of the month will be effective on the first day of the following month.
- Applications postmarked after the 20th day of the month will be effective on the first day of the second month following receipt.

☐ To select a future effective date, please indicate here (no more than 60 days after the postmarked date): First of (month)_____ (year) _____.

☐ Under limited circumstances, an ICHA applicant may choose to have the effective date of coverage retroactive to an earlier date. In order for this opportunity to apply, the applicant must first apply for coverage and be rejected by a health insurance carrier licensed in the State of Iowa. If the applicant then applies to ICHA no later than the end of the full calendar month following the date of original application to the health carrier, the ICHA applicant may choose the first of the month of the ICHA application as the effective date for coverage.

SECTION VII: NON-TOBACCO DISCOUNT

Do you smoke or use tobacco products or have you smoked or used tobacco products during the 12 months immediately preceding the date of this application. ☐ Yes ☐ No If you answered NO, you are eligible for the Non Tobacco-User Rate.

"Smoke or use tobacco products" means any use of cigarettes, pipes, cigars or any other tobacco products regardless of the number of times, frequency or method of use.

If your tobacco usage status changes, you must notify ICHA immediately. You may also be required by us to re-certify this status in the future.

If it is determined that the status reported is incorrect, we will retroactively collect historical differences in premiums before claims will be paid and the Tobacco-User rate will apply.

SECTION VIII: DISCLOSURE CERTIFICATION

By signing this form, I certify the following:

(a) All of the answers provided are true and complete.

(b) I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under the ICHA coverage and may face other penalties for prosecution and collection.

(c) The ICHA coverage will not be effective until this application has been signed, submitted in full by the applicant, and approved by ICHA. Deposit of premium payment does not guarantee coverage. The payment will be refunded for an applicant who is not eligible for coverage.

(d) I have read the privacy notice at the end of this brochure.

SIGNATURE OF APPLICANT (OR CUSTODIAL PARENT/GUARDIAN IF APPLICANT IS UNDER AGE 18 OR NOT LEGALLY COMPETENT) _____ DATE: (MONTH / DAY / YEAR) _____

PRINT APPLICANT'S NAME _____

SECTION IX: PRODUCER INFORMATION

I/We certify that during an in-person interview with applicant, I/we asked each question exactly as written and recorded the answers provided by the applicant completely and accurately.

☐ Yes ☐ No

_____ _____
Signature of Producer Date

_____ _____
Printed Name of Producer Telephone No.

Producer's License/ID Number _____

_____
Office Name

_____ _____
Office Address

MAIL COMPLETED APPLICATION TO:

ICHA
Attention: Enrollment
P.O. Box 1090
Great Bend, KS 67530

HEALTH INSURANCE PROGRAM OF IOWA

BANK SERVICE PLAN AUTHORIZATION FORM

To: The financial institution named on page 2 of this form.

So that you may comply with your depositor's request, this Pool agrees:

(a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by this Pool and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of that insurance.

(c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.

HIPIOWA
Iowa Comprehensive Health Association

Health Insurance Program of Iowa • P.O. Box 1090 • Great Bend, KS 67530

HIPIOWA
Iowa Comprehensive Health Association

REQUEST FOR BANK SERVICE PLAN

To Health Insurance Program of Iowa: Please use your Bank Service Plan to make payments by withdrawing funds by automatic debit entry from the account of:

Name as Shown on Account _____ Insured / Applicant

Name of Financial Institution _____ Branch

City _____ State _____ Zip

Transit/ABA No. _____ Account No. _____

Please indicate below the type of account to be debited.

Checking ☐ Savings ☐

As a convenience to me, I authorize you to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Health InsuranceProgram of Iowa. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until you receive 15 days' written notice from me to revoke it.**

X _____ **X** _____

Authorized signature as shown on the account _____ Date

ATTACH A VOIDED CHECK HERE

We will withdraw from your account the first Wednesday of each month except when it falls on the 1st, 2nd, or 3rd. In that case, we will then withdraw on the second Wednesday of the month.
If you have any questions call our customer service at 1.877.793.6880

Please return the Bank Service Plan to:
Health Insurance Program of Iowa
P. O. Box 1090
Great Bend, KS 67530

Iowa Comprehensive Health Association (HIPIOWA)

2010 Monthly Individual Premium Rates

Non Tobacco User

Plan	$1,000 Deductible		$1,500 Deductible		$2,500 Deductible		$5,000 Deductible		$10,000 Deductible	
Age \ Gender	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0 - 17	$207.06	$228.75	$190.08	$209.99	$164.40	$181.62	$123.62	$136.56	$99.39	$109.80
18	217.70	259.44	199.85	238.16	172.85	206.00	129.96	154.88	104.49	124.53
19	228.33	290.13	209.61	266.34	181.29	230.36	136.32	173.21	109.61	139.26
20	239.39	320.82	219.75	294.51	190.07	254.73	142.91	191.52	114.90	153.99
21	250.02	351.51	229.52	322.68	198.51	279.09	149.27	209.85	120.02	168.72
22	260.66	382.20	239.28	350.85	206.97	303.47	155.61	228.17	125.12	183.45
23	264.75	391.61	243.05	359.49	210.21	310.94	158.06	233.79	127.08	187.97
24	269.67	402.66	247.55	369.63	214.11	319.71	161.00	240.39	129.44	193.28
25	274.17	413.30	251.69	379.40	217.68	328.16	163.68	246.74	131.60	198.38
26	277.44	419.84	254.69	385.41	220.29	333.35	165.63	250.65	133.17	201.53
27	278.67	419.84	255.81	385.41	221.27	333.35	166.37	250.65	133.76	201.53
28	284.81	433.76	261.45	398.19	226.14	344.40	170.03	258.95	136.71	208.20
29	289.31	441.12	265.58	404.94	229.71	350.25	172.71	263.34	138.87	211.74
30	292.58	444.80	268.59	408.33	232.31	353.18	174.68	265.55	140.43	213.51
31	295.44	447.26	271.22	410.58	234.59	355.13	176.39	267.02	141.81	214.68
32	299.13	451.35	274.59	414.33	237.51	358.37	178.58	269.46	143.58	216.65
33	306.08	463.62	280.98	425.61	243.03	368.12	182.73	276.78	146.93	222.54
34	313.04	475.49	287.37	436.50	248.55	377.54	186.89	283.88	150.26	228.24
35	320.00	486.95	293.76	447.02	254.07	386.64	191.04	290.72	153.60	233.73
36	327.77	499.64	300.89	458.67	260.25	396.71	195.68	298.28	157.34	239.82
37	336.36	513.96	308.78	471.81	267.08	408.08	200.81	306.83	161.46	246.71
38	349.46	521.33	320.81	478.58	277.47	413.93	208.62	311.24	167.75	250.23
39	362.55	530.73	332.82	487.22	287.87	421.40	216.45	316.85	174.03	254.75
40	376.88	541.37	345.98	496.98	299.24	429.86	225.00	323.21	180.90	259.86
41	392.01	551.19	359.87	506.00	311.27	437.64	234.03	329.06	188.16	264.57
42	409.20	559.79	375.65	513.89	324.90	444.47	244.29	334.19	196.41	268.70
43	420.26	572.06	385.79	525.15	333.68	454.22	250.89	341.52	201.72	274.59
44	433.76	583.11	398.19	535.29	344.40	462.99	258.95	348.12	208.20	279.90
45	448.08	593.75	411.33	545.06	355.77	471.44	267.50	354.47	215.07	285.00
46	462.81	604.80	424.86	555.21	367.47	480.21	276.30	361.07	222.15	290.31
47	476.31	616.67	437.25	566.10	378.20	489.63	284.36	368.15	228.63	296.00
48	492.27	623.63	451.91	572.49	390.86	495.15	293.88	372.30	236.30	299.34
49	507.81	631.40	466.17	579.62	403.20	501.33	303.17	376.95	243.75	303.08
50	522.96	639.59	480.08	587.13	415.23	507.83	312.21	381.83	251.03	307.01
51	538.92	647.36	494.73	594.27	427.91	514.01	321.74	386.48	258.68	310.73
52	555.29	653.49	509.75	599.91	440.90	518.88	331.50	390.14	266.54	313.68
53	575.34	666.99	528.17	612.30	456.81	529.59	343.47	398.19	276.17	320.16
54	595.38	679.28	546.57	623.57	472.74	539.34	355.44	405.53	285.78	326.06
55	616.26	690.74	565.73	634.10	489.30	548.45	367.91	412.37	295.80	331.55
56	637.95	703.01	585.63	645.36	506.52	558.18	380.85	419.70	306.21	337.44
57	660.86	717.33	606.68	658.50	524.72	569.57	394.53	428.25	317.21	344.31
58	696.87	729.20	639.72	669.41	553.32	578.99	416.03	435.33	334.50	350.01
59	733.29	742.70	673.16	681.80	582.23	589.70	437.78	443.39	351.98	356.49
60	770.94	757.02	707.72	694.95	612.12	601.08	460.25	451.94	370.05	363.38
61	811.86	771.75	745.28	708.47	644.61	612.77	484.68	460.74	389.69	370.44
62	857.28	786.08	786.98	721.62	680.67	624.14	511.80	469.29	411.50	377.31
63	898.61	800.40	824.93	734.76	713.49	635.52	536.46	477.84	431.33	384.20
64	941.99	815.54	864.74	748.67	747.93	647.54	562.37	486.87	452.15	391.46
65+	986.99	830.27	906.06	762.18	783.68	659.24	589.23	495.68	473.76	398.54

Optional Maternity Rider

All Ages, Add: $272.50 Must Elect Maternity Rider Upon Initial Enrollment.

Age/Rate is calculated as age upon enrollment, then attained age every January 1st thereafter.

Iowa Comprehensive Health Association (HIPIOWA)

2010 Monthly Individual Premium Rates

Tobacco User

Plan	$1,000 Deductible		$1,500 Deductible		$2,500 Deductible		$5,000 Deductible		$10,000 Deductible	
Age \ Gender	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0 - 17	$239.16	$264.21	$219.54	$242.54	$189.89	$209.78	$142.77	$157.73	$114.80	$126.83
18	251.45	299.66	230.82	275.07	199.64	237.93	150.11	178.88	120.69	143.84
19	263.72	335.10	242.10	307.62	209.39	266.06	157.46	200.06	126.60	160.85
20	276.50	370.55	253.82	340.16	219.53	294.21	165.06	221.21	132.71	177.86
21	288.78	405.99	265.10	372.69	229.28	322.35	172.40	242.37	138.62	194.87
22	301.05	441.44	276.38	405.23	239.06	350.51	179.73	263.54	144.51	211.89
23	305.79	452.31	280.71	415.22	242.79	359.13	182.55	270.03	146.78	217.10
24	311.48	465.08	285.92	426.93	247.29	369.27	185.96	277.65	149.49	223.23
25	316.67	477.36	290.70	438.20	251.42	379.02	189.05	284.99	152.00	229.13
26	320.45	484.91	294.17	445.16	254.43	385.02	191.31	289.50	153.81	232.76
27	321.87	484.91	295.46	445.16	255.56	385.02	192.15	289.50	154.49	232.76
28	329.52	501.86	302.51	460.71	261.65	398.48	196.73	299.60	158.18	240.89
29	335.31	511.26	307.80	469.32	266.24	405.95	200.18	305.21	160.95	245.40
30	339.68	516.41	311.84	474.08	269.70	410.04	202.80	308.30	163.04	247.89
31	343.59	520.16	315.42	477.51	272.82	413.01	205.14	310.55	164.93	249.68
32	348.48	525.83	319.89	482.70	276.71	417.50	208.04	313.92	167.27	252.39
33	357.20	541.05	327.90	496.68	283.62	429.59	213.24	323.00	171.47	259.71
34	365.94	555.84	335.94	510.27	290.55	441.35	218.48	331.85	175.65	266.82
35	374.72	570.21	344.00	523.46	297.51	452.76	223.71	340.43	179.87	273.71
36	384.47	586.07	352.94	538.02	305.28	465.33	229.53	349.88	184.56	281.31
37	395.22	603.90	362.81	554.37	313.82	479.49	235.95	360.53	189.72	289.88
38	410.96	613.08	377.27	562.80	326.31	486.78	245.34	366.02	197.27	294.27
39	426.72	624.68	391.73	573.45	338.82	495.98	254.76	372.93	204.84	299.84
40	443.96	637.73	407.57	585.44	352.50	506.37	265.05	380.73	213.11	306.12
41	462.18	649.86	424.28	596.57	366.98	515.99	275.93	387.96	221.84	311.93
42	482.85	660.54	443.27	606.39	383.39	524.48	288.26	394.34	231.77	317.06
43	496.74	676.17	456.00	620.73	394.41	536.88	296.55	403.68	238.44	324.57
44	513.57	690.41	471.45	633.78	407.78	548.18	306.59	412.17	246.51	331.40
45	531.42	704.18	487.83	646.44	421.95	559.13	317.25	420.39	255.08	338.01
46	549.83	718.50	504.74	659.60	436.56	570.50	328.25	428.94	263.91	344.90
47	566.81	733.83	520.34	673.67	450.05	582.66	338.39	438.09	272.07	352.23
48	587.78	744.62	539.58	683.55	466.68	591.21	350.90	444.53	282.14	357.41
49	608.36	756.41	558.47	694.38	483.03	600.60	363.20	451.59	292.01	363.09
50	628.61	768.78	577.05	705.74	499.11	610.41	375.27	458.96	301.73	369.02
51	649.94	780.71	596.64	716.69	516.06	619.89	388.01	466.10	311.96	374.73
52	671.90	790.73	616.79	725.90	533.49	627.84	401.12	472.07	322.50	379.56
53	698.46	809.73	641.19	743.33	554.57	642.92	416.97	483.41	335.27	388.68
54	725.18	827.36	665.72	759.50	575.79	656.91	432.93	493.94	348.08	397.14
55	753.08	844.08	691.32	774.87	597.93	670.20	449.58	503.91	361.47	405.15
56	782.13	861.89	717.98	791.21	621.00	684.33	466.92	514.55	375.42	413.70
57	812.85	882.32	746.21	809.96	645.41	700.56	485.27	526.76	390.17	423.50
58	857.15	896.91	786.86	823.37	680.58	712.16	511.71	535.46	411.44	430.52
59	901.95	913.52	827.99	838.61	716.13	725.33	538.47	545.37	432.93	438.48
60	948.26	931.14	870.50	854.79	752.91	739.34	566.10	555.89	455.16	446.96
61	998.60	949.26	916.70	871.41	792.87	753.71	596.16	566.72	479.31	455.64
62	1,054.46	966.87	967.98	887.60	837.23	767.69	629.52	577.23	506.15	464.09
63	1,105.29	984.50	1,014.66	903.75	877.59	781.70	659.85	587.75	530.54	472.56
64	1,158.65	1,003.11	1,063.62	920.87	919.95	796.47	691.71	598.85	556.14	481.49
65+	1,214.00	1,021.23	1,114.46	937.49	963.92	810.86	724.76	609.68	582.72	490.20

Optional Maternity Rider

All Ages, Add: $314.74 Must Elect Maternity Rider Upon Initial Enrollment.

Age/Rate is calculated as age upon enrollment, then attained age every January 1st thereafter.

Iowa Comprehensive Health Association (HIPIOWA)

2010 Monthly Individual Premium Rates

Medicare Carveout Plan (Without Drug Benefits)

$1,000 Deductible

Rate Class	Non-Tobacco User		Tobacco User	
Age \ Gender	Male	Female	Male	Female
0 - 17	$52.38	$57.87	$60.49	$66.84
18	$55.08	$65.64	$63.61	$75.81
19	$57.76	$73.39	$66.72	$84.76
20	$60.57	$81.16	$69.96	$93.75
21	$63.25	$88.93	$73.06	$102.72
22	$65.94	$96.69	$76.15	$111.67
23	$66.99	$99.07	$77.37	$114.43
24	$68.22	$101.86	$78.79	$117.66
25	$69.36	$104.56	$80.11	$120.78
26	$70.18	$106.21	$81.06	$122.68
27	$70.50	$106.21	$81.43	$122.68
28	$72.06	$109.74	$83.37	$126.97
29	$73.18	$111.60	$84.82	$129.34
30	$74.02	$112.53	$85.95	$130.65
31	$74.74	$113.16	$86.92	$131.61
32	$75.67	$114.19	$88.15	$133.03
33	$77.43	$117.30	$90.36	$136.89
34	$79.20	$120.30	$92.58	$140.62
35	$80.95	$123.19	$94.80	$144.25
36	$82.92	$126.40	$97.26	$148.27
37	$85.09	$130.03	$99.99	$152.79
38	$88.41	$131.89	$103.96	$155.11
39	$91.72	$134.26	$107.95	$158.02
40	$95.35	$136.96	$112.33	$161.34
41	$99.18	$139.45	$116.94	$164.41
42	$103.53	$141.63	$122.16	$167.13
43	$106.32	$144.73	$125.67	$171.07
44	$109.74	$147.52	$129.93	$174.67
45	$113.37	$150.21	$134.46	$178.15
46	$117.09	$153.01	$139.11	$181.78
47	$120.51	$156.01	$143.40	$185.65
48	$124.54	$157.77	$148.71	$188.37
49	$128.47	$159.75	$153.91	$191.38
50	$132.31	$161.82	$159.04	$194.50
51	$136.35	$163.78	$164.44	$197.52
52	$140.49	$165.33	$169.99	$200.05
53	$145.56	$168.75	$176.71	$204.85
54	$150.63	$171.85	$183.46	$209.32
55	$155.91	$174.75	$190.51	$213.54
56	$161.40	$177.85	$197.88	$218.05
57	$167.19	$181.48	$205.65	$223.23
58	$176.31	$184.48	$216.85	$226.92
59	$185.52	$187.90	$228.19	$231.12
60	$195.04	$191.52	$239.91	$235.57
61	$205.39	$195.25	$252.63	$240.16
62	$216.88	$198.87	$266.77	$244.60
63	$227.34	$202.50	$279.63	$249.07
64	$238.32	$206.32	$293.13	$253.78
65	$258.51	$221.67	$317.97	$272.65
66	$262.56	$223.00	$322.95	$274.29
67	$266.67	$224.32	$328.00	$275.92
68	$273.78	$228.18	$336.75	$280.66
69	$281.05	$232.11	$345.70	$285.49
70+	$311.91	$255.21	$383.65	$313.90
Optional Maternity Rider				
All Ages, Add:	$272.50 Non-Tobacco User		$314.74 Tobacco User	
Must Elect Maternity Rider Upon Initial Enrollment				

Age/Rate is calculated as age upon enrollment, then attained age every January 1st thereafter.

HIPIOWA
Iowa Comprehensive Health Association

P. O. Box 1090
Great Bend, KS 67530
1-877-793-6880
www.HIPIOWA.com

PERSONAL REPRESENTATIVE FORM

The purpose of this form is to designate a member's Personal Representative(s) for discussion and disclosure of Personal Health Information by the Iowa Comprehensive Health Association (ICHA), and Benefit Management Inc. (BMI), as their plan administrator. This designation is voluntary and in no way affects benefits, claims processing and payment, or eligibility status.

Member Information

Member Name	Birth Date	Policy #

Type of Information

ICHA and BMI may discuss or release Personal Health Information (PHI) to my Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through ICHA, and BMI, the health plan administrator.

Authorized Use and/or Disclosure

I authorize ICHA and BMI to release PHI to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider, or other person subject to federal privacy laws, my PHI may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. ICHA and BMI are not responsible should my Personal Representative further disclose my protected PHI information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI.

Disclosure Limitations: _____

_____

Expiration and Revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan administrator. Revocation will not affect any action that ICHA or BMI has taken, or any information that has already been released based upon prior authorizations.

Designation of Personal Representative(s)

Name of Authorized Person	Relationship to Member	SS#
Name of Authorized Person	Relationship to Member	SS#
Name of Authorized Person	Relationship to Member	SS#

Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

_____

Signature of Member/Legal Representative **Date**

_____

Printed Name of Legal Representative **Description of Legal Representative's Relationship to Member**

Iowa Comprehensive Health Association (ICHA)

Notice of Privacy Practices

This Notice of Privacy Practices describes how the Iowa Comprehensive Health Association (referred to in this Notice as "ICHA") may use and disclose your protected health information.

This Notice has been drafted in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164.

Questions and Further Information. If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact ICHA using the Contact Information provided at the end of this Notice.

ICHA'S RESPONSIBILITIES

ICHA is required by law to maintain the privacy of your protected health information. It is obligated to provide you with a copy of this Notice setting forth ICHA's legal duties and its privacy practices with respect to your protected health information. ICHA must abide by the terms of this Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of when ICHA is permitted or required to use or disclose your protected health information.

Treatment. ICHA may disclose your medical information when requested by a doctor, hospital or other provider requiring the information to appropriately treat you.

Payment. ICHA may use or disclose your protected health information to fulfill its responsibilities for coverage and providing benefits as established under ICHA. For example, ICHA may disclose your protected health information when a provider requests information regarding your eligibility for benefits under ICHA, or it may use your information to determine if a treatment that you received was medically necessary.

***Health Care Operations*.** ICHA may use or disclose your protected health information to operate the ICHA program. ICHA contracts with service providers – called business associates – to perform various functions on its behalf. For example, (i) ICHA may contract with a service provider to perform the administrative functions necessary to pay your medical claims; (ii) to provide you with information about a disease management program; (iii) to respond to a customer service inquiry from you; (iv) in connection with fraud and abuse detection and compliance programs, or (v) to survey you concerning how effectively ICHA is providing services, among other issues.

To You or Your Designee Upon Your Authorization: ICHA may disclose your protected health information to you or someone who has the legal right to act for you. You retain the right to give us permission, via a written authorization, to use your protected health information or release it to whomever you choose for any purpose. If you give such an authorization you have the right to cancel it at any time.

ICHA considers the activities described above key for the proper administration of your health plan. There are also other limited circumstances in which ICHA must release your protected health information. These include:

Required by Law. ICHA may use or disclose your protected health information to the extent required by federal, state, or local law.

Public Health Activities. ICHA may use or disclose your protected health information for public health activities that are permitted or required by law.

Health Oversight Activities. ICHA may disclose your protected health information to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions.

Lawsuits and Other Legal Proceedings. ICHA may disclose your protected health information in the course of any judicial or administrative proceeding or in response to an order of a court, subpoena, or a discovery request (to the extent such disclosure is expressly authorized).

For Emergency Situations and Disaster Relief Purposes. ICHA also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then, using professional judgment, ICHA may determine whether the disclosure is in your best interest.

Abuse or Neglect. ICHA may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

Coroners, Medical Examiners, and Funeral Directors. ICHA may disclose protected health information to a coroner or medical examiner when necessary for identifying a deceased person or determining a cause of death.

Organ and Tissue Donation. ICHA may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research. ICHA may disclose your protected health information to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information, or (2) the research involves a limited data set which includes no unique identifiers (information such as name, address, social security number, *etc.*, that can identify you).

To Prevent a Serious Threat to Health or Safety. Consistent with applicable laws, ICHA may disclose your protected health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. It also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military. Under certain conditions, ICHA may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities.

National Security and Protective Services. ICHA may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide ICHA with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information.

YOUR RIGHTS

The following is a description of your rights with respect to your protected health information.

Right to Request a Restriction. You have the right to request a restriction on the protected health information ICHA uses or discloses about you for treatment, payment or health care operations. ICHA is not required to agree to any restriction that you request.

Right to Request Confidential Communications**.** If you would like to request that ICHA communicate with you at an alternative location, (for example: you may request that we send materials to a P.O. Box instead of your home address), please submit your request, including the reason for the request, in writing to the address listed at the end of this notice. ICHA will accommodate a request for confidential communications that is reasonable.

Right to Request Access**.** You have the right to inspect and copy protected health information that is maintained by ICHA. You must submit your request in writing. Should you request any information, please submit your request to the address listed at the end of this notice. If you request copies, ICHA will charge you 5 ¢ per page, and $30.00 per hour for labor to copy your protected health information, as well as postage if you request copies be mailed to you.

Right to Request an Amendment**.** You have the right to request an amendment of your protected health information held by ICHA if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing request to the address listed at the end of this notice and must set forth a reason(s) in support of the proposed amendment.

In certain cases, ICHA may deny your request for an amendment. For example, ICHA may deny your request if the information you want to amend is accurate and complete or was not created by ICHA. If ICHA denies your request, you have the right to file a statement of disagreement.

Right to Request an Accounting. You have the right to request an accounting of certain disclosures ICHA has made of your protected health information. Your request must be submitted in writing and sent to the address listed at the end of this notice. This list will not include any disclosures that were made to you or your personal representative, disclosures made for treatment, payment or healthcare operations activities as described within this notice or for disclosures made prior to the mandatory effective date of April 14, 2004. You are entitled to one accounting free of charge during a twelve-month period. There will be a charge to cover ICHA's costs for additional requests within that twelve-month period.

Right to Submit a Complaint. If you believe ICHA has violated your privacy rights, you may complain to ICHA or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with ICHA and this must be submitted in writing and sent to the address listed at the end of this notice.

CHANGES TO THIS NOTICE

ICHA reserves the right to change the provisions of this Notice and make the new provisions effective for all protected health information that it maintains. If ICHA makes a material change to this Notice, it will provide a revised Notice to you at the address that ICHA has on record for the participant enrolled in ICHA.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on April 14, 2004.

CONTACT INFORMATION

To exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact:

ICHA Administrator

Chad Somers, Privacy Official

P.O. Box 1090

Great Bend, KS 67530