APPLICATION

AND

POLICY DESCRIPTION

KHIA

Kansas Health Insurance Association

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KANSAS HEALTH INSURANCE ASSOCIATION

Thank you for your interest in the Kansas Health Insurance Association (KHIA). This comprehensive health insurance policy was created by the Kansas State Legislature to provide access to health insurance coverage for all residents of the state. Contained in this packet is an application and information that will explain eligibility, benefits and the cost of each policy. Please carefully review all information.

If you have questions at any time while completing the application, contact our customer service department at 1-800-362-9290. If preferred, prospective insured's may also use the assistance of a licensed insurance agent.

AGENT INFORMATION

KHIA will pay a $100 fee to Kansas state licensed insurance agents who assist applicants in filling out a KHIA application form.

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

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

If you need to assist your client with issues regarding their account including claim information, you must first enter into a Business Associate Agreement with KHIA. An insured's protected health and financial information will not be released to you without the valid Business Associate Agreement.

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

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

The following Producer Fee Arrangement directs the payment of the producer fee to the appropriate entity. In order to avoid delays in your producer fee payment, please complete the form and return it with the prospect's application. Your signature, as producer, is required under the Agent's Statement on the form.

PRODUCER FEE ARRANGEMENT

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

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

Agent Name	Firm or Agency	
Agent or Agency Address	Telephone Number	
Agent's Insurance License Number	□ Copy of License Attached □ Copy of License Already on File	Expiration Date
Agent or Agency Tax ID Number	□ Copy of IRS Form W-9 Attached □ Copy of IRS Form W-9 Already on File	Contact Person

AGENT'S STATEMENT : I have a valid agent's or broker's license in the State of Kansas for accident and health insurance. **PLEASE RETURN A COPY OF YOUR KANSAS LICENSE and Form W-9 WITH THIS APPLICATION.**

I have assisted the applicant in completing this application for KHIA. To the best of my knowledge and belief, the information contained in the application and affirmation form are correct and complete. I certify that the applicant meets the KHIA eligibility standards.

______________________________ X______________________________

Print Agent's Name **Agent's Signature**

HOW TO CONTACT US

ON THE WEB:

www.khiastatepool.com

BY PHONE:
800-362-9290

BY FAX:
620-793-1199

VIA MAIL:

KHIA
P.O. Box 1090
Great Bend, KS 67530

VIA FED EX or UPS:

KHIA
2015 16th Street
Great Bend, KS 67530

ADMINISTERED BY: Benefit Management, Inc (BMI)

GENERAL ELIGIBILITY REQUIREMENTS

Coverage is available for individuals who meet the criteria in one of the following categories:

❖ MEDICAL CONDITION ELIGIBILITY (requires six months of Kansas residency)

- Eligibility based on a Medical Condition, current premium rate or involuntary termination of an individual health policy.

  - ✓ Applicants must have applied for health insurance and been rejected by two carriers because of a health condition; or
  - ✓ Applicant must have been quoted a rate more than the KHIA rate for a similar policy; or
  - ✓ Applicant must have been accepted for health insurance subject to an exclusion of a pre-existing disease or condition; or
  - ✓ Applicant must have had previous individual insurance coverage involuntarily terminated for a reason other than non-payment of premiums; 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 in which a pre-existing condition exclusion applies.

❖ <u>FEDERALLY DEFINED ELIGIBILITY</u> (no length of residency required)

- ✓ Applicant, as of the date on which the individual seeks coverage under this Policy, has aggregate creditable coverage of 18 months or more;
- ✓ 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;
- ✓ 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 in which a pre-existing condition exclusion applies;
- ✓ Applicant's most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to non-payment of premiums or fraud;
- ✓ Applicant, if offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, elected such coverage; and
- ✓ Applicant has exhausted such continuation coverage under such provision or program, if the applicant elected the continuation coverage.

❖ <u>FEDERALLY DEFINED ELIGIBILITY for FTAA</u> (no length of residency required)

"FTAA" means Federal Trade Adjustment Assistance under the Federal Trade Adjustment Assistance Reform Act of 2002, public law 107-210.

- ✓ Applicant, as of the date on which the individual seeks coverage under this Policy, has three months of prior creditable coverage as described in subsection (c) of K.S. A. 40-2124;
- ✓ 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;
- ✓ 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 in which a pre-existing condition exclusion applies;
- ✓ Applicant's most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to non-payment of premiums or fraud;
- ✓ Applicant must be eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986.

NOT ELIGIBLE FOR KHIA COVERAGE

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

- ✓ You are eligible for Medicare or Medicaid benefits;
- ✓ You have terminated coverage in KHIA within the last 12 months, unless you can show continuous other coverage which has been involuntarily terminated for any reason other than non-payment of premiums, except that this provision shall not apply with respect to an applicant who is a Federally Defined Eligible Individual;
- ✓ The Policy has paid out benefits equal to or in excess of the lifetime maximum on your behalf;
- ✓ You have access to health insurance through an employer-sponsored group or self-funded plan, including coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), except that the requirement for exhaustion of any available COBRA or state continuation is waived whenever such person: a) is eligible for the credit for health care costs under section 35 of the internal revenue code of 1986, and b) has three months of prior creditable coverage as described in subsection (c) of K.S.A. 40-2124. A person may maintain other coverage for the period of time that person is satisfying any pre-existing condition exclusion period under this Policy. A person may maintain this Policy for the period of time the person is satisfying a pre-existing condition exclusion or under another health insurance policy intended to replace this Policy.
- ✓ You are eligible for any other public or private program that provides or indemnifies for health services.
- ✓ If you cease to meet the eligibility requirements of this section the Policy will be terminated the date the next premium payment would otherwise be due.
- ✓ Coverage shall cease on the date state law requires cancellation of the Policy.

HOW TO APPLY TO KHIA

❖ MEDICAL CONDITION ELIGIBILITY

Applicants seeking coverage based on medical condition eligibility must provide proof of Kansas residency by submitting one of the following documents:

Documentation must be dated at least six months prior to making your application and show your name and address.

- ✓ Kansas Driver's License; or
- ✓ Most recent Kansas tax return; or
- ✓ Utility bill showing current Kansas address; or
- ✓ Canceled check showing current Kansas address; or
- ✓ Other valid evidence that demonstrates proof of Kansas residency.

Applicants must also provide the following documentation to prove eligibility.

- ✓ 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 Kansas-licensed health insurers or health plans documenting the underwriting action taken. This documentation must indicate that coverage was refused; or
- ✓ If you are being charged more than the KHIA policy's rate for individual health care coverage, include the premium bill from your insurer and documentation showing the deductible amount of your policy; or
- ✓ If you have been accepted for health insurance coverage but are subject to a permanent exclusion of a pre-existing condition or disease, include the policy form that indicates the exclusion of coverage for specific conditions; or
- ✓ If your individual health insurance has been involuntarily terminated for any other reason than non-payment of premiums, please include the letter from the insurance company stating termination.

Applicants are subject to a 90-day pre-existing condition exclusion if there is a lapse in coverage of more than 31 days prior to enrollment in KHIA.

❖ FEDERALLY DEFINED ELIGIBILITY

Applicants seeking coverage based on Federally Defined Eligibility must provide one of the following documents to prove eligibility:

- ✓ A certificate of creditable coverage from all previous insurers, the aggregate of which is 18 months, or

- ✓ In the absence of a certificate of creditable coverage, alternate proof of coverage will be accepted. Alternate proof is described in more detail under *Proof of Creditable Coverage*.

- ✓ 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 certification of canceled coverage indicating the termination reason and termination date.

Applications must be received within 63 days of the termination date of other insurance or applicant will not be eligible for coverage based on Federally Defined Eligibility. Instead, they must meet medical condition criteria. (See medical condition) In such cases, six-month residency is required and pre-existing condition exclusions will be applied for 90 days.

❖ FEDERALLY DEFINED ELIGIBILITY FOR FTAA

Applicants seeking coverage based on Federally Defined Eligibility for FTAA must provide the following documents to prove eligibility:

- ✓ A certificate of creditable coverage from all previous insurers, the aggregate of which is three months, or
- ✓ In the absence of a certificate of creditable coverage, alternate proof of coverage will be accepted. Alternate proof is described in more detail under *Proof of Creditable Coverage*.
- ✓ The copy of your certification that you have been certified to receive Trade Adjustment Assistance Act (TAA) benefits.

Proof of Creditable Coverage — Required Documentation for KHIA Application

In certain instances, individuals may establish creditable coverage through means other than certificates. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the applicant, the applicant has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the applicant may make a demonstration if one of the following occurs:

(a) An entity has failed to provide a certificate within the required time period;

(b) The applicant has creditable coverage but an entity may not be required to provide a certificate of the coverage;

(c) The coverage is for a period before July 1, 1996;

(d) The applicant has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to KHIA.

(e) The applicant lost a certificate that the applicant had previously received and is unable to obtain another certificate.

An issuer must take into account all information that it obtains or that is presented on behalf of an applicant to make a determination, based on the relevant facts and circumstances, whether or not an applicant has 18 months of creditable coverage. An issuer must treat the applicant as having furnished a certificate if the applicant attests to the period of creditable coverage, the applicant presents relevant corroborating evidence of some creditable coverage during the period, and the applicant cooperates with the issuer's efforts to verify the applicant's coverage. For this purpose, cooperation includes providing (upon the issuer's request) a written authorization for the issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While an issuer may refuse to credit coverage if the applicant fails to cooperate with the issuer's efforts to verify coverage, the issuer may not consider an applicant's inability to obtain a certificate to be evidence of the absence of creditable coverage.

Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating, coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

Creditable coverage (and waiting period or affiliation period information) may be established through means other than documentation, such as by a telephone call from the issuer to a third party verifying creditable coverage.

POLICY OPTIONS

KHIA offers four comprehensive preferred provider policies to choose from (each with pharmacy benefits).

- All policies are preferred provider (PPO) policies. These policies offer 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 our network. Upon application approval, you will be assigned to one of two networks depending upon your demographic location. The two available networks are Healthcare Preferred and Preferred Health Care. These policies offer a $1,500, $2,500, $5,000, and $10,000 deductible. The $2,500 deductible policy meets the requirements of a single Health Savings Account (HSA).

- The pharmacy benefit is included on all policies 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 and submitted through the network pharmacy. Pharmacy services are subject to the annual deductible, co-insurance and policy limitations.

SUMMARY OF BENEFITS

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

Once your application is approved, we will send you an identification card and your insurance policy. Provider information is available on the KHIA website www.khiastatepool.com or by calling the PPO network directly. Provider Directories are available by request. The policy provides the specific details of your benefits and the procedures you need to follow in order to obtain maximum benefits.

KANSAS HEALTH INSURANCE ASSOCIATION

Health Insurance Policy Highlights and Comparisons

The following table is NOT a complete summary or explanation of policy benefits.
Please refer to your policy for complete details of benefits.

Benefits	Policy Type $1,500	Policy Type $2,500	Policy Type $5,000	Policy Type $10,000
		HSA COMPLIANT		
Deductible, per Calendar Year				
Single	$1,500	$2,500	$5,000	$10,000
In Network Co-insurance				
Single	70% of the next $5,000; then benefits paid at 100%	70% of the next $8,333; then benefits paid at 100%	70% of the next $5,000; then benefits paid at 90%	70% of the next $15,000; then benefits paid at 90%
Out of Network Co-insurance	(Out of network expenses do not apply toward the out of pocket maximum and are never paid at 100%)			
Single	50% up to Lifetime Maximum	50% up to Lifetime Maximum	50% up to Lifetime Maximum	50% up to Lifetime Maximum
Benefit percentage payable After Deductible and Co-insurance	100%	100%	90%	90%
Individual Lifetime Maximum	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Prevention Services	$25 Co-pay then benefits paid 100%	Benefits are payable on the same basis as any other sickness.	$25 Co-pay then benefits paid 100%	$25 Co-pay then benefits paid 100%
Inpatient Hospital Care	Benefits are payable on the same basis as any other sickness. Prior authorization is required; $1,000 penalty for failure to obtain pre-authorization.			
Therapies: Physical, Speech & Occupational	Benefits are payable on the same basis as any other sickness.			
Oral Surgery	Benefits are payable on the same basis as any other sickness.			
Spinal Manipulation	Benefits are payable on the same basis as any other sickness; limited to 20 visits per calendar year.			
Maternity	Benefits are payable on the same basis as any other sickness benefit..			

KANSAS HEALTH INSURANCE ASSOCIATION

Health Insurance Policy Highlights and Comparisons

The following table is NOT a complete summary or explanation of policy benefits. Please refer to your policy for complete details of benefits.

Benefits continued	Policy Type $1,500	Policy Type $2,500	Policy Type $5,000	Policy Type $10,000
Emergency Room	Benefits are payable on the same basis as any other sickness.			
Ambulance	Benefits are payable on the same basis as any other sickness, subject to policy limitations.			
Durable Medical Equipment	Benefits are payable on the same basis as any other sickness, rental/purchase over $500 must be pre-authorized.			
Inpatient Mental Health/ Substance Abuse	Benefits are payable on the same basis as any other sickness, limited to the lesser of a combined maximum limit of 30 days or $7,500 in a calendar year.			
Outpatient Mental Health/ Substance Abuse	For Policies with $1,500, $5,000 and $10,000 deductibles eligible expenses for the first visit are reimbursed at 100%, deductible waived; visits 2-20 are subject to a $25 co-pay, deductible waived. For the $2,500 deductible Policy outpatient mental health/substance abuse benefits are payable on the same basis as any other sickness Calendar year maximum limit for the $1,500, $2,500, $5,000 and $10,000 deductible Policies: 20 visits for mental nervous and substance abuse combined.			
Skilled Nursing Care	Benefits are payable on the same basis as any other sickness, limited to 120 days per calendar year.			
Home Health Care	Benefits are payable on the same basis as any other sickness, limited to 40 visits per calendar year. Prior authorization required.			
Prescriptions Coverage is only available through the Prescription Network Provider. The member pharmacy **MUST** file the prescription claim on Your behalf.	Prescriptions are subject to the calendar year deductible, then reimbursed at 50% until the out of pocket expense is met; thereafter, prescriptions will be reimbursed at the benefit percentage payable of your policy up to the lifetime maximum of the policy.			
* On the $2,500 deductible policy deductibles and co-insurance are subject to change according to IRS code section 220 in relation to the CPI. Consult your tax attorney, accountant, or other qualified advisor for information relating to the steps necessary to maintain a compliant individual HSA policy.				

APPLICATION CHECKLIST

☐ Did you choose a health care policy? ($1,500, $2,500, $5,000 or $10,000 Deductilbe Policy)
Please Note: Changing policies can only be done effective January 1st each year.
Once you have selected a deductible, a lower deductible cannot be chosen at a later date.

☐ Did you choose an eligibility category (Federally Defined Eligibility, Federally Defined FTAA or Medical Condition Eligibility)?

☐ Did you include a copy of the documentation required for eligibility?

Medical Condition **Federally**	**Defined**	**Federally Defined FTAA**
☐ Proof of Residency, and	☐ Certificate of Creditable Coverage, or	☐ Certificate of Creditable Coverage, or
☐ Proof of Eligibility	☐ Alternative Proof of Coverage, and	☐ Alternative Proof of Coverage, and
(as described on page 6)	☐ Proof of Eligibility (as described on page 6)	☐ FTAA Certification

☐ Did you identify any other health care coverage in effect?

☐ Did you complete the Health Status Questionnaire?

☐ Did you complete and sign the Affirmation Form? Did you initial in the appropriate space?

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

☐ If you prefer to have your premium automatically withdrawn from an account, did you complete and sign the Authorization Agreement for Preauthorized Payments? Did you attach a voided check?

☐ Have you included the correct premium payment? **The first months' premium payment must be included with the application.**

☐ Did you date and sign the Application?

If you have questions about any of the above information or need assistance completing the application, please contact our customer service department at 1-800-362-9290.

Kansas Health Insurance Association

2011 Individual Monthly Premium Rates

Non-Tobacco User

Age	$1,500 Male	Deductible Female	$2,500 Male	Deductible Female	$5,000 Male	Deductible Female	$10,000 Male	Deductible Female
Child	$292.92	$292.92	$225.59	$225.59	$186.56	$186.56	$157.70	$157.70
17	292.92	404.11	225.59	323.52	186.56	257.26	158.17	202.25
18	292.92	686.20	226.46	526.32	186.56	428.50	158.65	268.75
19	292.92	746.35	227.34	571.15	186.56	436.04	160.16	270.81
20	291.31	791.01	227.34	604.69	188.32	440.93	161.09	272.32
21	290.74	822.43	227.34	628.58	189.18	443.64	161.66	273.44
22	291.52	842.65	227.34	644.31	190.23	444.59	162.08	274.33
23	293.50	853.52	227.34	653.24	191.54	444.17	162.50	275.10
24	296.55	856.74	228.56	656.60	193.18	442.72	163.09	275.88
25	300.57	853.84	231.77	655.52	195.22	440.55	163.98	276.76
26	305.47	846.20	235.74	650.99	197.70	437.93	165.28	277.82
27	311.19	835.03	240.42	643.91	200.69	435.12	167.07	279.15
28	317.68	821.42	245.75	635.07	204.24	432.32	169.45	280.79
29	324.91	806.33	251.70	625.15	208.38	429.72	172.46	282.80
30	332.86	790.57	258.26	614.75	213.15	427.47	176.15	285.22
31	341.53	774.85	265.40	604.39	218.59	425.71	180.55	288.08
32	350.94	759.76	273.13	594.49	224.73	424.54	185.69	291.39
33	361.10	745.79	281.46	585.41	231.59	424.04	191.57	295.17
34	372.05	733.34	290.41	577.44	239.20	424.29	198.19	299.43
35	383.84	722.71	300.01	570.78	247.58	425.32	205.54	304.16
36	396.50	714.12	310.29	565.61	256.73	427.18	213.61	309.37
37	410.10	707.74	321.28	562.04	266.68	429.87	222.38	315.03
38	424.70	703.63	333.04	560.11	277.43	433.40	231.81	321.13
39	440.36	701.84	345.60	559.84	289.00	437.76	241.89	327.66
40	457.16	702.32	359.02	561.22	301.38	442.93	252.58	334.60
41	475.16	705.03	373.34	564.20	314.58	448.89	263.85	341.92
42	494.44	709.85	388.63	568.69	328.59	455.61	275.66	349.61
43	515.07	716.65	404.93	574.61	343.43	463.06	288.00	357.64
44	537.10	725.28	422.28	581.83	359.08	471.19	300.83	365.99
45	560.61	735.58	440.75	590.24	375.54	479.97	314.14	374.64
46	585.66	747.37	460.36	599.71	392.81	489.37	327.91	383.59
47	612.30	760.49	481.17	610.12	410.88	499.35	342.13	392.80
48	640.57	774.77	503.19	621.35	429.75	509.89	356.80	402.29
49	670.52	790.08	526.47	633.31	449.40	520.96	371.94	412.04
50	702.16	806.29	551.01	645.91	469.83	532.56	387.57	422.06
51	735.53	823.31	576.84	659.10	491.04	544.69	403.71	432.35
52	770.62	841.11	603.94	672.84	513.01	557.35	420.42	442.95
53	807.43	859.68	632.32	687.14	535.74	570.57	437.75	453.86
54	845.93	879.07	661.94	702.04	559.23	584.40	455.80	465.14
55	886.08	899.41	692.78	717.66	583.47	598.89	474.64	476.82
56	927.84	920.88	724.79	734.12	608.45	614.12	494.40	488.95
57	971.11	943.74	757.90	751.64	634.18	630.18	515.21	501.62
58	1,015.81	968.34	792.05	770.48	660.64	647.22	537.22	514.90
59	1,061.83	995.12	827.12	790.97	687.85	665.36	560.61	528.87
60	1,109.02	1,024.63	863.01	813.54	715.81	684.79	585.59	543.66
61	1,157.22	1,057.51	899.60	838.67	744.51	705.70	612.37	559.38
62	1,206.26	1,094.52	936.72	866.93	773.98	728.33	641.22	576.18
63	1,255.91	1,136.55	974.21	898.99	804.21	752.95	672.41	594.20
64	1,305.94	1,184.62	1,011.87	935.62	835.21	779.85	706.24	613.63
65	1,567.13	1,421.54	1,214.25	1,122.75	1,002.26	935.82	847.49	736.36

[1] H S A Plan, Health Savings Account: This plan is designed to meet the requirements of a Single Health Savings Account. Please consult your banking institution or financial advisor regarding H S A plans.

Kansas Health Insurance Association
2011 Individual Monthly Premium Rates
Tobacco User

Age	$1,500 Male	Deductible Female	$2,500 Male	Deductible[1] Female	$5,000 Male	Deductible Female	$10,000 Male	Deductible Female
Child	$342.72	$342.72	$263.94	$263.94	$218.27	$218.28	$185.06	$185.07
17	342.72	472.81	263.94	378.52	218.27	300.99	185.06	236.64
18	342.72	802.85	264.96	615.80	218.27	501.34	185.62	314.44
19	342.72	873.23	265.99	668.24	218.27	510.17	187.39	316.85
20	340.83	925.49	265.99	707.49	220.34	515.89	188.48	318.61
21	340.17	962.25	265.99	735.44	221.34	519.06	189.15	319.93
22	341.08	985.90	265.99	753.84	222.57	520.18	189.63	320.96
23	343.39	998.61	265.99	764.29	224.10	519.68	190.13	321.87
24	346.96	1,002.38	267.41	768.23	226.02	517.98	190.82	322.78
25	351.66	998.99	271.17	766.96	228.40	515.44	191.86	323.81
26	360.45	998.51	278.17	768.17	233.29	516.76	195.03	327.83
27	367.20	985.33	283.69	759.82	236.82	513.44	197.15	329.39
28	378.04	977.50	292.44	755.73	243.04	514.46	201.64	334.14
29	389.89	967.60	302.04	750.18	250.05	515.67	206.95	339.36
30	399.43	948.68	309.91	737.70	255.78	512.97	211.38	342.26
31	413.26	937.57	321.13	731.31	264.49	515.11	218.47	348.57
32	424.64	919.31	330.49	719.33	271.92	513.69	224.68	352.58
33	440.55	909.87	343.38	714.20	282.54	517.33	233.71	360.11
34	453.91	894.67	354.31	704.47	291.82	517.63	241.79	365.31
35	468.28	881.71	366.01	696.36	302.04	518.90	250.76	371.08
36	483.73	871.23	378.55	690.05	313.21	521.16	260.61	377.43
37	500.32	863.44	391.96	685.68	325.35	524.44	271.30	384.33
38	518.13	858.43	406.30	683.33	338.47	528.75	282.81	391.78
39	537.24	856.24	421.63	683.01	352.58	534.06	295.11	399.75
40	557.74	856.83	438.00	684.69	367.68	540.38	308.15	408.21
41	579.70	860.14	455.48	688.33	383.78	547.65	321.89	417.15
42	603.22	866.02	474.13	693.81	400.88	555.85	336.31	426.52
43	628.38	874.31	494.01	701.02	418.98	564.93	351.36	436.32
44	655.26	884.85	515.19	709.83	438.08	574.85	367.02	446.51
45	683.95	897.41	537.71	720.09	458.16	585.56	383.25	457.07
46	714.50	911.80	561.64	731.64	479.23	597.03	400.05	467.97
47	747.00	927.80	587.02	744.34	501.27	609.21	417.40	479.22
48	781.49	945.22	613.89	758.05	524.29	622.06	435.30	490.79
49	818.03	963.89	642.29	772.64	548.26	635.57	453.77	502.69
50	863.66	991.73	677.75	794.47	577.89	655.05	476.71	519.13
51	904.70	1,012.68	709.51	810.69	603.98	669.97	496.56	531.80
52	955.57	1,042.98	748.89	834.32	636.13	691.11	521.32	549.26
53	1,001.21	1,066.00	784.07	852.05	664.32	707.51	542.81	562.79
54	1,057.41	1,098.84	827.43	877.56	699.04	730.50	569.74	581.42
55	1,107.60	1,124.26	865.98	897.07	729.33	748.61	593.30	596.02
56	1,169.07	1,160.31	913.24	924.99	766.65	773.79	622.94	616.08
57	1,223.60	1,189.11	954.96	947.06	799.06	794.03	649.16	632.04
58	1,279.92	1,220.11	997.98	970.80	832.41	815.49	676.89	648.77
59	1,337.90	1,253.86	1,042.17	996.63	866.69	838.35	706.37	666.38
60	1,397.36	1,291.04	1,087.40	1,025.06	901.92	862.83	737.84	685.01
61	1,458.10	1,332.46	1,133.49	1,056.72	938.09	889.18	771.59	704.82
62	1,519.89	1,379.10	1,180.27	1,092.33	975.21	917.70	807.94	725.99
63	1,582.45	1,432.06	1,227.50	1,132.73	1,013.30	948.72	847.23	748.70
64	1,645.49	1,492.62	1,274.96	1,178.88	1,052.37	982.62	889.87	773.17
65	1,974.59	1,791.14	1,529.95	1,414.66	1,262.84	1,179.14	1,067.84	927.81

[1] H S A Plan, Health Savings Account: This plan is designed to meet the requirements of a Single Health Savings Account. Please consult your banking institution or financial advisor regarding H S A plans.

KANSAS HEALTH INSURANCE ASSOCIATION APPLICATION

REQUESTED EFFECTIVE DATE ____________________________

Eligible applicants who are accepted for KHIA membership <u>will have coverage effective on the first day of the month following the date their application is accepted</u> and the KHIA Administrator receives appropriate premiums. Applicant may request a later effective date.

1. **Applicant Information** ________________________________ **[ ] Male** **[ ] Female**

   Social Security Number

   Date of Birth ____________

   A. **Name:** ____

   Last **First** **Middle**

   Address: ____

   Number **Street**

   ____

   City **State** **Zip** **County**

   Telephone Number: ______________________________ ________________________

   Length of time at address?

   B. ____ ____________________

   Name of your employer (if any) **Employer telephone number**

   ____

   Address of Your Employer

2. **Deductible Selection**

   Please select the deductible amount you prefer under your KHIA Policy.

   [ ] $1,500 [ ] $2,500 [ ] $5,000 [ ] $10,000

3. **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-user status changes, you must notify KHIA immediately. You may also be required by us to re-certify this status in the future. If it is determined that the status of tobacco-user rate class is incorrect, we will retroactively collect historical difference in premiums before claims will be paid, and we will start applying the tobacco-user rate.

4. **KHIA requires the first month's premium with your application. Amount Enclosed $________________________**

5. **How did you hear about KHIA?**____

6. **Have you previously been covered by KHIA?** [ ] Yes [ ] No If, Yes, when did coverage end___________________

HEALTH STATUS QUESTIONNAIRE

Answers you provide in this questionnaire will help KHIA determine how to best serve you. KHIA may be able to provide you with additional benefits in the form of counseling, case management, or healthy lifestyles programs. Completing the questionnaire is required. Information you provide will *not* be used to determine your eligibility. If you have questions while completing the questionnaire, you may contact our customer service department at 1-800-362-9290 or use the assistance of your healthcare provider.

6. Heig ht_____________________ Weight _____________________

7. Diseases, Treatments or Diagnoses: In the past 10 years, have you had a problem with, been treated by a physician, or taken medication for any of the following conditions. Please check all that apply.

- □ Alcoholism, drug addiction or abuse
- □ Anemia or any blood condition or disease
- □ Arthritis, rheumatism or painful joints
- □ Asthma, bronchitis or chronic lung condition
- □ Backache, injury or disability
- □ Cancer, leukemia, tumor
- □ Cerebrovascular hemorrhage or stroke
- □ Coronary artery or heart disease
- □ Depression
- □ Diabetes
- □ Digestive or stomach disorder
- □ Epilepsy, seizure or convulsions
- □ Hepatitis
- □ Hypertension or high blood pressure
- □ Immune system or tested positive for HIV, including AIDS
- □ Kidney problems or renal failure
- □ Liver, pancreas or gallbladder problems
- □ Multiple sclerosis or cystic fibrosis
- □ Nervous or mental trouble
- □ Obesity
- □ Osteoporosis
- □ Peripheral artery disease
- □ Pituitary gland / growth disorders
- □ Other condition (please specify below)

8. Physician: Please provide the following information for your primary care or specialty care physician(s):

Physician Name	Address	Phone Number

9. Pharm acy: If you have been prescribed medications within the last year, please provide the name of the pharmacy or clinic dispensing these medications to you:

Name of Pharmacy or Clinic	Address	Phone Number

10. Pas t Treatments: If during the past six months, you have had an operation, or been hospitalized, or had any other condition for which you have had a diagnosis or treatment, please provide details below:

Dates of treatment or hospitalization	Diagnosis, treatment, or reason for visit	Were you hospitalized?	Name and Address of Doctor and/or Hospital

11. Future Treatments: Has future surgery, diagnostic testing or medical treatment been recommended for you?
[ ] Yes [ ] No

If "Yes", please provide the following information.

Date Dia	gnosis	Type of surgery or treatment

12. Federally Defined Eligible Individuals Only

A Federally Defined individual is a resident of Kansas, and has aggregate creditable coverage of 18 months or more; 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; 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 in which a pre-existing condition exclusion applies; most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to non-payment of premiums or fraud; if offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, elected such coverage; and has exhausted such c**ontinuation coverage under such provision or program.**

A. Are you currently enrolled in a group policy, COBRA or State continuation? [ ] Yes [ ] No

Or have you been enrolled in a group policy, COBRA or State continuation that terminated within the last 63 days? [ ] Yes [ ] No If yes, what is the termination date of coverage? ________________________.

B. Are you currently enrolled in Medicaid, Medicare or Healthwave(SCHIP)? [ ] Yes [ ] No

If yes, what is the termination date of the coverage? ______________________ .

C. If previous coverage was under Medicaid, Medicare or Healthwave (SCHIP) was it terminated within the last 63 days? [ ] Yes [ ] No

D. Are you currently covered by any health insurance plan? [ ] Yes [ ] No.
If so, please provide the name of the company and type of coverage ______________________________________

If you answered YES to A, B or C you MUST complete the information in this box.

Name of Insured	Name of Insurance Co.	(circle one)	(circle one)	(circle one)
		Your Employer Spouse's Employer	COBRA continuation State continuation	Medicaid Healthwave(SCHIP) Medicare
		Your Employer Spouse's Employer	COBRA continuation State continuation	Medicaid Healthwave(SCHIP) Medicare

You must include a copy of your certificate of creditable coverage or alternate proof from all previous insurance companies, the aggregate of which must equal 18 months.

12. Applicant signature.

NOTE: If the applicant is less than 18 years of age, a parent or legal guardian must sign below to indicate consent. I understand that coverage issued is based on all statements and answers recorded above. These statements and answers are complete and true. I understand any false statement or misrepresentation in the application may result in loss of coverage under the Policy.

X____ ______________________________

Applicant's Signature if 18 or older **Date**
(Parent's or Legal Guardian's Signature for children under 18)

If your eligibility is due to Federally Defined criteria, please skip to the Affirmation Form on Page .

14. Federally Defined Eligible Individuals for FTAA Only

A Federally Defined Eligible Individual for FTAA means that the applicant must be eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986. "FTAA" means Federal Trade Adjustment Assistance under the Federal Trade Adjustment Assistance Reform Act of 2002, public law 107-210. The applicant is a resident of Kansas, has three months of prior creditable coverage or more, and the 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; 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 in which a pre-existing condition exclusion applies; has not had their most recent coverage terminated based on a factor relating to non-payment of premiums or fraud.

A. Are you currently enrolled in a group policy, COBRA or State continuation? [ ] Yes [ ] No

Or have you been enrolled in a group policy, COBRA or State continuation that terminated within the last 63 days? [ ] Yes [ ] No If yes, what is the termination date of coverage? ________________________.

B. Have you been certified to receive Trade Adjustment Assistance Act (TAA) benefits? [ ] Yes [ ] No

C. Are you currently enrolled in Medicaid, Medicare, or Healthwave (SCHIP)? [ ] Yes [ ] No

If yes, what is the termination date of coverage? ______________________.

E. If previous coverage was under Medicaid, Medicare, or Healthwave(SCHIP) was it terminated within the last 63 days? [ ] Yes [ ] No

F. Are you currently covered by any health insurance plan? [ ] Yes [ ] No.
If so, please provide the name of the company and type of coverage ______________________________________

If you answered YES to A, B, C or D you MUST complete the information in this box.

Name of Insured	Name of Insurance Co.	(circle one)	(circle one)	(circle one)
		Your Employer Spouse's Employer	COBRA continuation State continuation	Medicaid Healthwave(SCHIP) Medicare
		Your Employer Spouse's Employer	COBRA continuation State continuation	Medicaid Healthwave(SCHIP) Medicare

You must include your certificate of creditable coverage or alternate proof from all previous insurance companies, the aggregate of which must equal three months.

Applicant signature.
NOTE: If the applicant is less than 18 years of age, a parent or legal guardian must sign below to indicate consent. I understand that coverage issued is based on all statements and answers recorded above. These statements and answers are complete and true. I understand any false statement or misrepresentation in the application may result in loss of coverage under the Policy.

X ____ ____________________

Applicant's Signature if 18 or older Date **Date**
(Parent's or Legal Guardian's Signature for children under 18)

If your eligibility is due to Federally Defined criteria, please skip to the Affirmation Form on Page _ And initial that selection.

15. <u>**Medical Condition Eligible Individuals Only**</u>

Applicants must have been a resident of Kansas for six months prior to enrollment in KHIA; applied for health insurance and been rejected by two carriers because of a health condition; or must have been quoted a rate more than the KHIA rate; or must have been accepted for health insurance subject to a pre-existing condition exclusion or policy waiting period; or must have had previous individual insurance coverage involuntarily terminated for a reason other than non-payment of premiums; and are 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 in which a pre-existing condition exclusion applies.

Are you applying for coverage because:

A. You have been rejected by two carriers? [ ] Yes [ ] No
You must submit copies of the rejections.

B. You have been quoted or are paying a rate on an Individual policy that is higher than KHIA? [ ] Yes [ ] No
You must provide a copy of your most recent billing or premium quote and documentation showing the deductible amount of your policy.

Name of Applicant	Name of Insurance Co.	Premium amount. Paying or Quoted	Current Deductible	Are you canceling because of premiums?
		$	$	[ ] Yes [ ] No

C. Have you been accepted for insurance subject to a permanent pre-existing condition exclusion? [ ] Yes [ ] No
If so, you must provide documentation from the carrier of the pre-existing condition exclusion.

D. Are you currently covered by any health insurance plan? [ ] Yes [ ] No

If so, please provide the name of the company and type of coverage ____

E. Do you have access to or are you eligible for any health insurance plan including but not limited to Medicare, Medicaid or group health insurance for yourself or through a spouse or as a dependent? [ ] Yes [ ] No

17. A pplicant signature.

NOTE: If the applicant is less than 18 years of age, a parent or legal guardian must sign below to indicate consent. I understand that coverage issued is based on all statements and answers to questions as recorded above. These statements and answers are complete and true. I understand any false statement or misrepresentation in the application may result in loss of coverage under the Policy.

X ____ ____________________

Applicant's Signature if 18 or older Date
(Parent or Legal Guardian Signature for child under age 18)

If your eligibility is due to Medical Condition criteria, <u>please initial that section on the Affirmation Form on the next page.</u>

<u>AFFIRMATION FORM</u> KANSAS HEALTH INSURANCE ASSOCIATION

Please read carefully and sign below.

I hereby apply for KHIA coverage, as offered by the State of Kansas. I understand and agree to everything listed below:

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

I will pay monthly the premiums billed by KHIA 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 KHIA because of a medical condition or current premium rate, benefits will not be payable during the 90 days after coverage is effective, for any condition for which medical advice, care or treatment was recommended or received from a medical practitioner as to such conditions during the six month period immediately preceding the effective date of coverage. I understand that this exclusion may not apply to the extent that I satisfied a waiting period immediately prior to my application for this policy, subject to approval of this application and KHIA verification of previous coverage. I understand that if I have prior creditable coverage the 90 day waiting period may be waived.

<u>Federally Defined:</u>

_________ **Please <u>initial if you are qualifying under Federally Defined</u>.** I represent that I am a resident of Kansas, and I have included a copy of my certificate(s) of creditable coverage or alternate proof .

<u>Federally Defined FTAA:</u>

_________ **Please <u>initial if you are qualifying under Federally Defined FTAA</u>.** I represent that I am a resident of Kansas, I have included a copy of my certificate(s) of creditable coverage or alternate proof , and I am certified to receive Trade Adjustment Assistance Act (TAA) benefits.

<u>Medical Condition:</u>

_________ **Please <u>initial if you are qualifying under Medical Conditions</u>.** I represent that I have been a resident of Kansas for at least six months prior to making this application. Proof of my residency (copy of driver's license, Kansas tax return, utility bill, canceled check or other valid evidence) is attached to this application.

I am eligible for coverage with KHIA 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 more than this Program's rate;

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

_____ I have had my <u>individual</u> health insurance policy involuntarily terminated for reasons other than non-payment of premiums.

I understand that my KHIA policy 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 by the Kansas Health Insurance Association.

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

I understand that I am not eligible for KHIA if I have other health insurance coverage.

I understand that if I receive covered services from health care providers who are not in the KHIA provider networks, my coinsurance amount for those services will decrease to 50% of eligible expenses, and these expenses will not apply toward my out-of-pocket expense maximum amount on all policies except the $2,500 deductible policies.

I will be responsible for obtaining Pre-admission Authorization prior to any non-emergency admission to a hospital, Home Health Care services or Durable Medical Equipment services over $500.

I will notify KHIA know when I am no longer eligible for coverage because I have changed residence; become eligible for Medicare, Medicaid, or, Healthwave (SCHIP) benefits; or I am eligible for other health insurance coverage.

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______________________________________ ____________________

Applicant's Signature if 18 or older **Date**

(Parent's or Legal Guardian's Signature for child under 18)

KANSAS HEALTH INSURANCE ASSOCIATION

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize The Kansas Health Insurance Association to initiate debit entries to my account indicated below, and the depository named below to debit the same to such account. Debits will be on the 5th of every month unless it falls on a holiday or weekend then it will be the next business day.

INSURED'S NAME: ____________________ Insured's Social Security Number: ____________________

Please indicate the type of account. [ ] Checking [ ] Savings

ATTACH A VOIDED CHECK

A deposit ticket will not be accepted

The voided check must match the account number given on this form.

DEPOSITORY
NAME ____________________ BRANCH ____________________

CITY ____________________ STATE ____________ ZIP ____________________

TRANSIT/ABA—NO. ____________________ ACCOUNT NO. ____________________

This authority is to remain in full force and effect until the Kansas Health Insurance Association and depository have received written notification from me of its termination in such time to allow the Kansas Health Insurance Association and depository a reasonable opportunity to act on it.

X ____________________ DATE ____________________

Signature must be from a person who has authority to sign on the account to be drafted.

KANSAS HEALTH INSURANCE ASSOCIATION

DECLARATION TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING PROCEDURES IN THE EVENT OF A TERMINAL CONDITION.

Kansas insurance law requires that persons insured under the Kansas Health Insurance Association be provided with a Declaration that would allow that insured person to elect to have life-sustaining procedures withheld or withdrawn in the event of a terminal illness.

You should retain a copy of the Declaration with your policy and a copy must be provided to your physician.

NOTICE

This Declaration form is strictly voluntary. However, please sign the Declination section if you do not want to sign the Declaration Form.

DECLARATION

This Declaration is made this ______________ day of ____________________, 20_______.
I, ____, being of sound mind, willfully and voluntarily declare my desire that my dying shall not be artificially prolonged by the circumstances set for below.

If at any time I should have an incurable injury, disease or illness that is certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and those physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedures deemed necessary to provide me with comfort.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this Declaration be honored by my family and physician(s) as the final expression of my legal right to refuse any medical treatment and accept the consequences from such refusal.

I understand fully the impact of this Declaration and I am emotionally and mentally competent to make this Declaration. I further understand that this Declaration is made voluntarily and under no obligations.

SIGNED____

CITY, COUNTY AND STATE OF RESIDENCE ____

WITNESS

This declarant is personally known to me and it is my belief that the declarant is of sound mind. I did not sign the declarant's signature above for, or at the direction of, the declarant. I am eighteen (18) years of age or older. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for the declarant's medical care.

WITNESS _____________________________________ DATE ________________________

WITNESS _____________________________________ DATE ________________________

DECLINATION

I have read this Declaration and do not want to have life-sustaining procedures withdrawn in the event of a terminal condition.

SIGNED_______________________________________ DATE ______________________________

Benefit Management Inc.

PERSONAL REPRESENTATIVE FORM

PO Box 1090
Great Bend, KS 67530
(800) 362-9290
www.khiastatepool.com

The purpose of this form is to designate a member's Personal Representative(s) for discussion and disclosure of Personal Health Information and Personal Financial Information by the Kansas Health Insurance Association. and 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 Number

Type of Information

KHIA and BMI may discuss or release Personal Health Information (PHI) and Personal Financial Information (PFI) 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 the Kansas Health Insurance Association (KHIA), and BMI, the health plan administrator.

Authorized Use and/or Disclosure

I authorize KHIA and BMI to release PHI and PFI to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health policy 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 and PFI may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. KHIA and BMI are not responsible should my Personal Representative further disclose my protected PHI and PFI 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 or PFI.

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 policy 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 KHIA 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	Last four digits of SS#
Name of Authorized Person	Relationship to Member	Last four digits of SS#
Name of Authorized Person	Relationship to Member	Last four digits of 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.

X____

Signature of Applicant/Legal Representative **Date**

____

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

NOTICE OF PRIVACY PRACTICE
Effective January 1, 2008

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

What is this Notice?

This Notice tells you:

• How Kansas Health Insurance Association (the "Plan") uses and gives out personal information about you (such as name, address, date of birth, social security number) and your health (such as medical conditions, treatment given to you by doctors, and tests you have had). We refer to this personal information as your "health information."
• The Plan's responsibilities in protecting your health information.
• Your rights concerning your health information.
• How you can use those rights and contact us.

What are the Plan's Responsibilities to You about the Privacy of Your Protected Health Information?

Your health information is personal. The Plan must protect the privacy of this information. We protect it in all places where we use or store it. The Plan uses the least amount of health information needed to do our work. Only persons who need your health information to provide you services or to assist the Plan in providing its services see it. The Plan has policies about physically and electronically safeguarding your information. This Notice is required to be given to you so that you understand the way in which we may use or give out your protected health information, and your rights regarding that information. The Plan is required by law to follow the terms of this Notice.

How Do We Use or Disclose Health Information about You?

The Plan is permitted to use and give out your health information in order to do our business. Information also may be shared with others who give you care or help pay for it. This could include doctors, hospitals, and governmental or private agencies. This document tells some of the ways the Plan uses and gives out information without a Privacy Authorization (special permission from you).

Treatment Purposes

Coordination of Treatment and Coverage. The Plan sometimes helps decide what medical treatment may be covered by your health plan benefits and how treatment can be coordinated among your health care providers. The Plan does not provide medical treatment.

Payment Purposes

Benefits and Claims. The Plan and businesses and agencies we work with get and give out health information for:
• The billing and payment of claims.
• Reviewing health care given to members.
• Reviewing the use of benefits by members.

For example, your doctor or other health care provider must submit a claim form to the Plan's administrator listing services provided to you and your health information. The Plan's administrator needs this information so that it can pay your provider and send a form to the provider showing the services that you received and what the Plan will pay.

Health Care Operations Purposes

Enrollment, Case Management and Quality Improvement. The Plan may use your health information in our operations. For example, we will use your health information to determine whether you qualify for the Plan or to approve coverage for referrals or medical treatment requested by your doctor or other health care provider. We may give out information to others who must make decisions about your care or to resolve a dispute or investigate a claim we reject. This could include doctors, nurses, therapists, hospitals, etc. To make sure that you and other insureds are satisfied with the Plan, we will review and share health information to help us decide how to improve the Plan and the way we run it.

Other Uses and Disclosures of Health Information without Your Privacy Authorization

• *Business Associates* - To do business the Plan must work with many other organizations, such as administrators, governmental agencies, and professional firms. We must share health information with these organizations to the extent they need it to help the Plan. We try to make sure that these organizations protect the health information we share by having them sign an agreement with us.

• *The Plan will recognize certain people as your personal representatives without your having to complete a Privacy Authorization form* – For example, the Plan will automatically consider your spouse to be your personal representative as long as we can verify his/her identity by asking for certain facts of information and, if in person, by requiring photo identification. In addition, the Plan will consider a parent or guardian as the personal representative of an unemancipated minor, unless the law requires otherwise, as long as we can verify the individual's identity and authority by asking for certain facts of information. A spouse or parent may act on an individual's behalf, including requesting access to their PHI. Insureds, Spouses, unemancipated minors and Dependents that have reached the age of majority may, however, request that the Plan restrict information that goes to a family member as described in the section titled <u>*Uses and Disclosures with Your Privacy Authorization.*</u>

• *Individuals involved with your care or with payment for your care* - The Plan may give out your health information to a friend you name who is helping with your care or with payment for your care. The Plan also may give out information to a family member or friend if you are not available to agree to the disclosure and the Plan thinks it is in your best interests. For example, if you have a serious accident, the Plan may need to talk with a relative to facilitate health care decisions.

• *Lawsuits and Disputes* - The Plan must give out your health information if it is legally required under a court order or subpoena and certain procedural requirements are met. For example, a court may order the release of your information if you are involved in a lawsuit or legal dispute and the court orders the release of your information.

• *Law Enforcement* — The Plan may give out health information if police or other law enforcement officials request it for certain law enforcement purposes.

• *Legal Requirements/Health Oversight* - The Plan will give out health information when it is required to do so by a federal, state or local law, including to government agencies that are authorized to oversee our business activities. For example, we must give information if requested by the Secretary of the Department of Health and Human Services to investigate whether we are following our privacy responsibilities.

• *Research* - We may give out health information for limited research purposes but only if there is an independent committee that has reviewed the research proposal and put safeguards in place to protect the privacy of your health information.

Uses and Disclosures with Your Privacy Authorization

We must receive your written permission (Privacy Authorization) any time we want to use or give out your health information in any way that is not described above. You may take away this Privacy Authorization (permission) at any time, but uses or disclosures we already made while your permission was still effective cannot be changed. To cancel a Privacy Authorization, please send a written note to the Plan Administrator at the address at the end of this Notice.

What Are Your Rights Regarding Your Health Information?

Kansas Health Insurance Association wants you to know your rights regarding your health information. *You may do any of the following by*

sending a written request to the Plan's Compliance Officer. The address is at the end of this Notice.

Right to Receive the Plan's Notice of Privacy Practices

Each new member will receive a printed copy of the Notice in the enrollment material provided to new insureds IMPORTANT: *The Plan has the right to change its privacy practices and parts of this Notice and to make the new practices and parts effective for all protected health information that it already has and may get in the future. All members will be mailed a new copy (or a notice concerning where to obtain a new copy) at least once every 3 years.*

Right to Request Confidential Communications

You have the right to ask that the Plan communicate with you about personal health information in a certain way (for example, by mail or telephone) or in a certain location (for example, at home or at work). The Plan will do this in as many cases as possible. Requests should tell how you want us to contact you and/or where you want us to contact you.

Right to Request Restrictions

You have the right to ask us to limit the ways we use or give out your health information for treatment, payment, and health care operation reasons, or to a family member or friend involved in your care or payment for it. This is called requesting a restriction. *The Plan is not required to agree to your request for a restriction.* If we agree, we still may disclose your health information when required by law.

Requests for a restriction on the use of your information should include:
1. The information you wish to restrict.
2. Whether you wish to restrict the use of information, the giving out of information, or both.
3. To whom you want the restriction to apply.

Right to Access

You have the right to look at and get a copy of your protected health information contained in a specific set of records, called a designated record set. The Plan's designated record set includes enrollment, claims and payment, case management, and utilization management information (your doctor, not the Plan, has your medical records). The Plan has the right to keep you from having or seeing all or part of your designated record set for certain reasons, which the Plan will tell you in writing. The Plan also will give you information about how you can file an appeal if you are not satisfied with the Plan's decision. We may charge you a fee for the cost of copying and/or mailing your records.

Right to Amend

You have the right to ask that information in your designated record set be changed if it is not correct. If the Plan agrees that the health information is not correct or complete, we will make the change unless we did not create or keep the information, or unless it is information the law does not permit us to change. We will tell you the reason if we cannot amend your record.

Right to an Accounting of Disclosures

You have the right to ask for an accounting of disclosures. This is a list of every time the Plan:

• Gave your health information without a Privacy Authorization to outside people or organizations other than you or those who are involved in your care.

• Gave or used your information when it was not part of normal treatment, payment, or health care operations. Your request must give a time period that you want to know about. The time period may not be longer than six (6) years and may not include dates before January 1, 2002.

What should you do if you have a complaint about the way that your health information is handled?

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan or to appeal a decision about your health information, send it in writing to the Plan's Compliance Officer. The address is at the end of this Notice. A notice in the Federal Register (the public library has copies) tells how to send a complaint to the U.S. Department of Health and Human Services.

IMPORTANT: *You will not lose your Kansas Health Insurance* Association *health plan membership or health care benefits if you file a complaint. We will not penalize you in any way*

Where should you send requests or questions about your protected health information?

Please send questions or requests, such as the examples listed in this Notice, to the Plan's Compliance Officer at the following address and telephone number:

Kansas Health Insurance Association
Compliance Officer
PO Box 1090
Great Bend, KS 67530
(800) 362-9290