WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

06 RM 045

Date: August 17, 2006

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Re: Comparison of Wyoming and Montana's High-Risk Health Insurance Pools

QUESTION

Compare and contrast the administration, benefits, and participant costs for the Wyoming and Montana high-risk health insurance pools. Consider whether there is evidence that Montana's pool provides better benefits with lower premiums.

ANSWER

Both the Wyoming and Montana high risk health insurance plans are administered by Blue Cross Blue Shield and appear to offer somewhat similar, or at least somewhat comparable, benefits. In addition, the premiums for participants for comparable plans do appear to be substantially lower in Montana than in Wyoming. However, due to differences in how the plans are structured, and particularly the out-of-pocket maximum expenditures, caution should be exercised when comparing the two states' plans. See Table 1, for a comparative assessment of participant premiums and other expenses for comparable plans.

Table 1. Wyoming and Montana Health Plan Participant Cost Comparison.

	WY Brown Plan	WY Gold Plan	MT Traditional #1	MT Traditional #2
Deductible	$5,000	$1,000	$5,000	$1,000
Co-pay	100% (up to deductible)	80% / 20%	80% / 20%	80% / 20%
Out-of-pocket maximum	$5,000	$2,000	$7,500	$5,000
Maximum Lifetime Benefit	$500,000	$750,000	$1,000,000	$1,000,000
Premium – Single Female, age 40	$503.80	$717.90	$267	$456
Premium – Single Male, age 55	$754.10	$1,074.70	$464	$792

Source: LSO Research staff summary based upon published benefit charts and premium rates, 2006.

WYOMING HEALTH INSURANCE POOL

Background and Eligibility.
The Wyoming Health Insurance Pool (WHIP) was created in 1990 through W.S. 26-43-101 et seq. and regulated by Chapter 41 of the Wyoming Insurance Department Regulations.[1] The intent of WHIP is to provide health insurance coverage to Wyoming residents who are denied traditional health insurance coverage due to existing medical conditions. The Wyoming Health Insurance Pool Board, consisting of seven members appointed by the insurance commissioner, operates the pool. Blue Cross Blue Shield, through a contract with the Board, administers the program.

Both the Wyoming and the Montana health insurance pools offer options designed to cover cost sharing amounts under Medicare Part A and Part B. Although directly related to the general health insurance pool, comparisons of the Medicare options are not considered in this memo.

Revenues for the Wyoming health insurance pool are currently derived from four sources: insurance company assessments, participant health insurance premiums, investment income, and based upon a recent developments this year, a federal grant. The pool does not currently receive support from a state appropriation.

Individuals eligible for coverage through WHIP must meet the following criteria:

- must be a Wyoming resident residing in Wyoming; and
- must provide proof that they have been refused coverage for health reasons by one insurer; or
  - ✓ have health insurance coverage more restrictive than WHIP's coverage; or
  - ✓ have health insurance coverage at a rate exceeding WHIP rates; or
  - ✓ is a federally eligible individual.[2]

Benefits.
Currently, two plan options are available from WHIP: The Brown Plan and The Gold Plan. The lifetime maximum benefit amount for the Brown Plan is $500,000; for the Gold Plan the maximum is $750,000, per individual. Coverage under both plan's include maternity care, hospitalization, medical surgery, prescription drugs, adult wellness and well child care, outpatient services, mental and substance abuse, and testing, supplies, ambulance services, etc. More complete information regarding the benefits of these plans, and WHIP generally, is included as Attachment A.

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[1] All of the benefit and cost information in this memo relates to the Wyoming Health Insurance Pool as of July 1, 2006. There are many participants that continue to follow the requirements and receive benefits from priors version of the plan. These "grandfathered" participants are still covered under last year's plans until December 31, 2006. Since those benefits and payment requirements are scheduled to expire, this analysis considers only the characteristics of the plans as approved for use as of July 1, 2006. All participants will be shifted to these plan requirements on or before January 1, 2007.

[2] A federally eligible individual, as defined by Health Insurance Portability and Accountability Act (HIPAA) and articulated by the Department of Insurance, is "an individual who has had at least 18 months of creditable coverage as of the date the individual seeks coverage under the Pool; whose most recent prior creditable coverage was under a group private or public health benefit plan; who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or Medicaid, and who does not have other health insurance coverage; whose most recent creditable coverage was not terminated based on nonpayment of premiums or fraud; and who, if offered, elected continuation coverage under a COBRA continuation provision or under a similar state program and exhausted such continuation coverage." Insurance Department staff report that there are few federal eligible individuals in the pool as portability is extended to all applicants if they have creditable coverage, or 90 days has not passed since an applicant had creditable coverage.

Premiums and Deductibles.
Every year the Wyoming Health Insurance Pool Board surveys five insurance companies to determine current standard market rates within the state in order to adjust and set rates. W.S. 26-43-107(b) requires WHIP rates may not exceed 200 percent of standard market rates. Statute also states, "The rates shall be set as close as practical to the lower end of the range provided by this subsection without undue risk of shifting more than fifty percent (50%) of the burden of assessments to private health insurance." According to Department of Insurance staff, premiums for WHIP currently approach the 200 percent maximum allowed by statute. Further, the assessments on insurance companies likely exceed the fifty percent burden referenced in statute. Monthly premiums, effective as of July 1, 2006, for WHIP plans are included as Attachment B. Below is a general illustration of the premiums, which vary by age of the participant, for the Brown and Gold Plans:

The Brown Plan premiums		The Gold Plan premiums	
Single Male:	$192.30 -$1,202.80	Single Male:	$274.10 - $1714.10
Single Female:	$192.30 - $1,074.20	Single Female:	$274.10 - $1,530.70

There are also out-of-pocket costs, including deductibles and co-payments. Once the maximum out-of-pocket amount has been met, the plan will pay 100 percent of reasonable and customary charges for services that are included in the plan's coverage. The rate structures, as described in the informational brochures, are as follows:

	Brown Plan	Gold Plan
Deductible	$5,000	$1,000
Insurance Provider Payments up to maximum/Member	100% / 0%	80% / 20%
Out-of-pocket Maximum	$5,000	$2,000

MONTANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (MCHA) PROGRAM

Background and Eligibility.
The MCHA program was created by the Montana Legislature in 1985, Mont. Code. Ann. Sec. 33-22-1501 et seq. to provide insurance to individuals considered uninsurable due to medical conditions. The general structure of Montana's health insurance pool is quite similar to Wyoming's pool. For example, it is managed by a board of eight directors. Further, Montana statute states, "the schedule of association plan premiums for eligible persons may not exceed 200% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state." [3] (Mont. Code Ann. 33-22-1512) Revenues supporting the plan chiefly include both premiums by paid by enrolled persons and assessments on insurance companies, as in Wyoming. However, in contrast, Montana's statute provides, "If the needs of the association plan and the association portability plan exceed the funds generated by the 1% assessment, the association is then authorized to spend any funds appropriated by the legislature for the support of the plans." (Mont. Code Ann. 33-22-1513(6)(ii))

Furthermore, unlike Wyoming, Montana offers three programs: *Traditional Program*, the *Premium Assistance Program* (*Pilot Program*), and the *Portability Plan* (federal eligibility). The *Traditional Program* most closely compares to Wyoming's plans and different deductible options within Montana's program align quite closely with Wyoming's Brown and Gold Plans. Therefore, for purposes of simplicity, the comparative assessment will focus on Montana's *Traditional* Program, though each is briefly described later in this memo. In general, eligibility for *Traditional* or *Pilot Program* coverage requires individuals be:

[3] Montana's statute also allows for reduced premiums for persons with income less than 150 percent of the federal poverty rate.

- residents of Montana for at least 30 days; and
- rejected or offered a restricted rider by two insurers within the last six months or have a specified illness (Attachment C); and
- not eligible for any other health insurance coverage[4], or have comparable coverage, but pay more than 150 percent of the average premium rate used to calculate MCHA premiums.

Insurance Plans Offered.
The three main insurance coverage plans available to those who are eligible include:

- The *Traditional Plan* is for individuals with medical conditions who have either been denied coverage or offered a significant rider on a medical condition. There is a 12-month waiting period before pre-existing conditions are covered. This plan is also available to those who are eligible for Medicare coverage, with Medicare as the primary payer and this plan the secondary payer (*Medicare Carve-Out Plan).* The *Traditional Plan* offers three levels of deductibles and, for purposes of comparison, is the most directly comparable to Wyoming's Gold and Brown Plans. The brochure for the *Traditional Plan* contains a list of benefits, as well as services covered, and is provided as Attachment D;

- The *Premium Assistance Program (Pilot Program)* is for individuals who have either been denied coverage or offered a significant rider on a medical condition, *and* meet certain income guidelines. The income guidelines are based on 150 percent of the federal poverty level and vary by family size. This plan offers the same coverage as the *Traditional Plan*, but, notably, the 12-month waiting period for pre-existing condition coverage is reduced to 4 months (if applicable). In addition, the premiums are subsidized during the pre-existing condition waiting period at a higher rate than after the waiting period has expired. This plan receives federal funds as a subsidy. This plan is also available to those who are eligible for Medicare coverage, with Medicare as the primary payer and this plan the secondary payer (*Medicare Carve-Out Plan*).

- The *MCHA Portability Plans* are for individuals who are federally eligible for coverage under MCHA and are leaving group coverage. Eligibility for this plan is as follows:
  - ✓ Montana resident;
  - ✓ most recent prior (18 months aggregate) creditable coverage was under a group health plan, governmental plan, or church plan;
  - ✓ do not have other health insurance coverage;
  - ✓ not eligible for coverage under a group health plan;
  - ✓ prior continuing coverage under COBRA or similar state program, which has been exhausted;
  - ✓ application for this program is made within 63 days of the last day of previous coverage;
  - ✓ individuals certified as eligible for Federal Trade Adjustment Act assistance and a health insurance tax credit or for Pension Benefit Guarantee Corporation assistance may also be eligible under specific circumstances.

[4] "Other health insurance coverage" includes any other comprehensive health coverage, such as employer group insurance, individual health coverage, Medicare (except individuals who are eligible to be covered by the Traditional Plan Medicare Carve-out Plan), or Medicaid.

Benefits.
Each plan program has similar benefit packages, but there are some important differences that deserve mentioning. All three plans cover, overall, the same services, with some difference in the pre-existing condition wait period.
The *Traditional Plan, Premium Assistance Plan, and Medicare Carve-Out Plan* cover the same services, but the Traditional plan requires a twelve (12) month pre-existing wait period, while the Premium Assistance Plan reduces the wait period to four (4) months. However, the pre-existing condition wait period does not apply to newborn children or children placed for adoption or if previous creditable coverage was not voluntarily canceled by the applicant, application was made within thirty days of the last day of previous coverage, or if all other options for health insurance, including COBRA or state continuation, have been exhausted.

The *Portability Plan* covers the same services as the *Traditional* and *Premium Assistance Plans*, but with a 12 month pre-existing condition wait period that may apply, depending upon circumstances. However, the requirement for 18 months of previous creditable coverage is waived for children under 18 months of age. In addition, children born to individuals covered under the *Portability Plan* can be placed on their own *Portability Plan* after 31 days of coverage on their parent's plan.

LSO Research staff are not able to conduct an actuarial assessment of the value of the benefits for both the Wyoming and Montana plans. However, consumers are likely unable to conduct that assessment either. Therefore, based upon the summary of benefits available and their structure, many of the same services appear to be covered. However, the structure of the prescription drug benefits, for example, are quite different among comparable plans between the two states and even among the Gold Plan and Brown Plan within Wyoming. A comparison would also depend upon whether the consumer required several less expensive prescriptions or a few expensive prescriptions. The Wyoming Plan advertises an adult wellness plan, not advertised by the Montana plan. These are just a few examples of the differences. It is likely there are other differences that have not been identified in this memorandum, but even those that have been identified serve as a hindrance to direct comparison.

In summary, the benefits of the two state plans are not identical. The quality of the benefits would likely depend upon the specific health characteristics of the consumer. Each reader may chose to compare the advertised covered benefits (which are likely not exhaustive) by considering page 2 of Attachment A, for Wyoming's plans and page 2 of Attachment D, for Montana's *Traditional Plan*. After such an assessment, it may be prudent to ask whether the difference in benefits, which may be subjective, justifies the demonstrated difference in monthly premiums. It would be difficult for this researcher to conclude that the difference in benefits for Montana's *Traditional Plan* justifies the difference in the premium levels. In fact, in some areas, Montana's benefits may be greater than Wyoming's, e.g., the maximum lifetime benefit. However, this determination has been made without the benefit of a full actuarial analysis and may differ depending upon the health of each consumer.

Premiums and Deductibles.
The premiums for Montana's plans are provided as Attachment E. Like Wyoming's plans, no family premiums and deductibles are offered. Individuals are required to apply to the program and pay separate premiums. The annual deductibles for the three plans are as follows:

Plan	Deductible	Co-pay	Maximum Annual Deductible & Co-pay limit (out-of-pocket expenses)
Traditional	$1,000	80/20	$5,000
	$2,500	80/20	$6,000
	$5,000	80/20	$7,500
Premium Assistance	$1,000	80/20	$5,000
Portability Plan	$1,000	70/30	$3,000
	$2,500	70/30	$5,000
	$5,000	70/30	$8,000

COMPARATIVE DISCUSSION – REVENUES AND OTHER FACTORS

Some state plans reportedly have the benefit of other sources of revenues which, in effect, serve to subsidize either the assessments on insurance companies or the premiums paid by participants. Historically, that does not appear to be the case for Wyoming and Montana, based upon discussions with each state's staff. No state funds are currently used in either plan, although both use a credit on the premium tax for insurance companies, which could serve as an indirect subsidy for the companies, but not for the plans. Also, in the recent past, neither the Wyoming plans or the Montana *Traditional Plan* benefited from outside revenue such as federal funds.[5] Table 2 illustrates a snapshot summary of the funding of the two state health insurance pools. The interest income has been removed from the revenue of both plans in order to provide a more comparable illustration. As you can see, the premiums paid by participants in Montana, even though they are lower, make up a similar, or even larger share of the core revenues of the two pools. This suggests that the revenue structure of the two pools is not substantially favorable for Montana. In addition, Wyoming's plan has historically reduced their net asset balance, suggesting reserves collected in a prior time period were, in effect, subsidizing the expenses to some degree during FY04 and FY05.

Table 2. FY04 and FY05 Key Revenue Statistics.

	Montana – Traditional Plan		Wyoming	
	FY04	**FY05**	**FY04**	**FY05**
Premiums Earned	$5,417,151	$6,839,638	$3,473,192	$3,850,905
Membership Assessment	$2,111,271	$1,535,508	$1,249,488	$1,599,614
% Assessments	28%	18%	26%	29%
Change in (Net) Asset Balance	$437,300	($677,019)	($756,877)	($1,214,720)

Source: LSO Research staff summary of Montana and Wyoming's Health Insurance Pool Statements of Operations.

Without a full comparative actuarial assessment of the two plans, it is not possible for LSO Research staff to definitively explain the reasons for premium disparities between the two pools. However, after removing the potential for a substantial revenue subsidy in some form, it appears that at least three potential causes still remain.

1) While the monthly premiums in Montana currently do appear to be comparatively lower than for Wyoming's pool, the potential total annual out-of-pocket expenses appear to be much more comparable. That is, although Montana's premiums are lower, the *Traditional Plan* in Montana has higher out-of-pocket

[5] Wyoming's plan will receive approximately $370,000 in federal funds for this year, according to Department of Insurance staff, and Montana's Premium Assistance Plan is federally subsidized, according to Montana plan documents.

maximum expenditures. In particular, for populations that include high users of medical services, the total, annual personal expenses may offer a better, or at least an additional, comparison of the true participant costs. Table 3 summarizes this comparison and directly relates to the same hypothetical populations illustrated earlier in Table 1.

Table 3. Annual, Potential Out-of-Pocket Expenses: Montana and Wyoming.

	Wyoming Brown Plan	Montana Traditional #1	WY Cost as a Percentage of MT's Plan	Wyoming Gold Plan	Montana Traditional #2	WY Cost as a Percentage of MT's Plan
1. Monthly Premium – Single Female age 40	$504	$267	189%	$718	$456	157%
2. Premium & Out-of-Pocket Potential – Single Female age 40	*$11,048*	*$10,704*	*103%*	*$10,616*	*$10,472*	*101%*
3. Monthly Premium – Single Male age 55	$754	$464	163%	$1,075	$792	136%
4. Premium & Out-of-Pocket Potential – Single Male age 55	*$14,048*	*$13,068*	*107%*	*$14,900*	*$14,504*	*103%*

Source: LSO Research staff computations.

As shown in Table 3, the total, annual out-of-pocket potential expenditures for pool participants in the two pools are quite close (rows 2 and 4), even though the monthly premiums in Montana's plan are currently substantially lower (rows 1 and 3).

2) Wyoming's pool had a *negative* equity balance at the close of FY05 of $290,197. Furthermore, the equity balance had been declining for at least two years. Therefore, it seems possible that the pool premiums and assessments were designed to insure that an appropriate equity balance is maintained. Put differently, the assessments and premiums in FY06 and FY07 may include this "build-up" effort.

3) Finally, the claims' history of the two pools could provide yet another explanation for the difference in premiums. In short, even if the eligibility criteria is similar, perhaps the claims experience is different between the two state pool populations. This difference in claims history is evident even between two plans in Montana for FY04 and FY05 for the *Traditional Plan* and the *Portability Plan*.

If you need anything further, please contact LSO Research at 777-7881.

ATTACHMENT A

WYOMING HEALTH INSURANCE POOL

Health Care Coverage Plan

DAVE FREUDENTHAL
GOVERNOR

This sales outline is designed to present the Wyoming Health Insurance Pool's health care benefits in an easy-to-read format and does not cover all information contained in the Subscription Agreement. Limitations and Exclusions in addition to those presented in this brochure do exist. This brochure is not a contract. For exact benefits and limitations, please refer to the Subscription Agreement.

Administered by:

BlueCross BlueShield of Wyoming
An independent licensee of the Blue Cross and Blue Shield Association.

4000 House Avenue
PO Box 2266
Cheyenne, WY 82003-2266
1.800.442.2376 or 307.634.1393

W04/2006

Purpose

The Wyoming Health Insurance Pool was created by the 1990 Wyoming Legislature to provide health insurance coverage to residents of Wyoming who are denied adequate health insurance. This plan is specially designed to meet the needs of those individuals who are unable to purchase health insurance for themselves because of existing health problems.

Benefits

Two options are available from the Wyoming Health Insurance Pool: The Brown Plan and The Gold Plan. Coverage under both plans includes hospital, surgical-medical, adult and well child care, maternity care, prescription drugs and other covered services including therapeutic equipment, medical supplies and dressings, ambulance services (up to $600 per ground trip, $6,000 air ambulance), accident-related dental care to natural healthy teeth, physical therapy (limited to 20 visits per calendar year), spinal manipulations (limited to $500 per member per calendar year), home health, hospice, high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support (limited to $100,000 per member per lifetime), diabetes screening and diabetes education services.

Out-of-Pocket Cost:

The out-of-pocket cost includes the deductibles and coinsurance paid by a member. Once the out-of-pocket maximum has been met, the plan will pay 100% of Reasonable and Customary charges for covered services.

Lifetime Maximum:

The Wyoming Health Insurance Pool will pay benefits up to the specified amount during a member's lifetime.

Membership & Eligibility

1. Applicant must be a resident of the state of Wyoming and certify occupation of a dwelling in the state of Wyoming.
2. Applicant will be required to complete an application for coverage. Upon administrative approval, coverage will begin on the 1st or the 16th of the month.
3. Applicant must meet one of the following eligibility requirements and provide proof of eligibility.
   a) Applicant has been refused coverage for health reasons by one insurer;
   b) Applicant has health insurance coverage more restrictive than the Pool;
   c) Applicant has health insurance coverage at a rate exceeding the Pool; or
   d) Applicant is a Federally eligible individual.
4. The following persons ARE NOT eligible for coverage:
   a) Any person who has coverage under health insurance or an insurance arrangement on the issue date of Pool coverage.
   b) Persons who are eligible for group health insurance or a group health insurance arrangement provided in connection with a policy, plan or program sponsored by an employer and subject to regulation as a group health plan under federal or state law, even though the employer coverage is declined.
   c) Any person who is, at the time of applic-tion, eligible for Medicaid health care benefits or Medicare by reason of age. Individuals on Medicare Disability under the age of 65 are eligible.
   d) Any person who terminated coverage in the Pool unless twelve (12) months have elapsed from the termination date.
   e) Any person on whose behalf the Pool has paid the lifetime maximum benefit under any Pool plan.
   f) Any person who is an inmate of a public institution.

Summary of Benefits

Benefits	*WHIP Brown	WHIP Gold
Deductible	$5,000	$1,000
Member Pays	0%	20%
Wyoming Health Insurance Pool Pays	100%	80%
Out-of-Pocket Maximum	$5,000	$2,000
Maternity	As any other illness	As any other illness
Adult Wellness	$150	$150
Well Child Care	At appropriate intervals as specified in the Subscription Agreement	At appropriate intervals as specified in the Subscription Agreement
Rehabilitation Therapy	$50,000 Lifetime Maximum	$50,000 Lifetime Maximum
Nervous, Mental & Substance Abuse	InPatient - $5,000 max/12 months Substance Abuse - $5,000 lifetime maximum OutPatient - 50% to $1,000 Calendar Year Maximum	InPatient - $5,000 max/12 months Substance Abuse - $5,000 lifetime maximum OutPatient - 50% to $1,000 Calendar Year Maximum
Inpatient & Outpatient Hospital, Physician & Medical Services	Subject to Deductible	Subject to Deductible and Coinsurance
Office & Ambulatory Surgical, Center, Surgery, Pre-Admission Testing	Subject to Deductible	Subject to Deductible Coinsurance Waived
Lifetime Maximum	$500,000	$750,000
Prescription Drugs	Subject to $5,000 Deductible (utilizing drug network discounts)	Drug Card Tier 1 - $5 & 20% Tier 2 - $10 & 20% Tier 3 - $20 & 50% Separate Calendar Year OOP $2,500

*This plan meets the criteria of a Qualified High Deductible Health Plan and is HSA eligible.

NOTE: *As shown above, there are two Plan options available: The Brown Plan and The Gold Plan. Upon enrollment in the Wyoming Health Insurance Pool and receipt of premium payment, switching between Plan options is not permitted.*

Managed Care Program

The Managed Care features of the Pool's health care coverage plan are designed to help control the cost of your health care without reducing your benefits. By using the features listed here, you can be assured of receiving quality health care in the most cost effective setting.

- *Pre-admission Authorization.* This is required on all non-emergency, non-maternity hospital admissions. It ensures that your hospitalization care is medically necessary and performed in the appropriate setting. It also allows you to confirm coverage prior to treatment.

  If pre-admission authorization is not obtained, benefits will be reduced by $200 after the deductible.

- *Pre-admission Testing.* Laboratory and radiology tests can generally be performed prior to the time you enter the hospital.

- *Office Surgery.* Surgery performed in a physician's office not only reduces out-of-pocket costs but may also be more convenient for you.

- *Generic Drugs.* A generic drug is a generally accepted substitute for a name-brand drug which may be more costly. You can generally recognize significant savings without sacrificing quality.

- *Second Surgical Opinion.* It is suggested that a second surgical opinion be sought to determine whether a recommended surgery is the best course of treatment.

Pre-existing Conditions

This program conforms to all Federal and State requirements regarding pre-existing condition exclusion periods including the definition of pre-existing conditions and the portability of pre-existing condition exclusion periods. Benefits will not be provided for pre-existing conditions for a period of twelve (12) months following the member's date of enrollment. Pre-existing conditions are those conditions for which medical advice, diagnosis, care or treatment was recommended or received in the six (6) months immediately preceding the enrollment date of coverage. Pregnancy existing on the enrollment date of coverage is considered a pre-existing condition.

In determining whether this pre-existing condition exclusion period applies to an eligible member, the Wyoming Health Insurance Pool will credit the time a member was previously covered by creditable coverage, provided there was not a significant break in coverage (90 days) from the previous creditable coverage. Waiting periods applicable under this individual health benefit plan shall not be considered in determining if a significant break in coverage has occurred, and will be credited toward any pre-existing condition exclusion period under this Agreement.

General Limitations and Exclusions

We will not pay for: Acupuncture, artificial conception, autopsies, biofeedback services, birth control pills and devices, complications of non-benefit services, convalescent care, cosmetic surgery, custodial care, diagnostic admissions, domiciliary care, experimental or investigative procedures, eye care, genetic counseling, obesity and weight loss, hair loss, hypnosis, tobacco dependency, orthognathic surgery, eye examinations, foot care services, hearing examinations, organ and tissue transplants including pre- and post-operative care and immunosuppressant drugs, sex change operations, subluxation, temporomandibular joint dysfunction, non-medical therapies, travel expenses and services or supplies covered under Worker's Compensation or provided by a government facility or institution.

I would like to enroll in the: ☐ Brown Plan ☐ Gold Plan

Enrollment may be delayed if application is not complete and accompanied by required documentation.

4000 House Avenue
P. O. Box 2419
Cheyenne, Wyoming 82003
1.888.557.2519 or
307.432.2828

Name _____ ☐ Male ☐ Female
Please Print

Address _____

City _____ Zip _____

Home Phone _____ Work Phone _____

Social Security Number _____ Date of Birth _____

Current Employer _____ Hrs Wkd Per Wk _____

For Office Use Only
Completed App. Rec'd. _____
Approval Date _____
Effective Date _____
Class _____
Group # _____
P.E. _____

Proof of eligibility must be attached.
I am eligible for coverage under the Wyoming Health Insurance Pool because (you need only to mark one to be eligible for coverage):

- ☐ I have been refused health insurance for health reasons by one health insurance company; **OR**
- ☐ I have health insurance coverage that is more restrictive than Pool coverage; **OR**
- ☐ I have health insurance coverage at a higher premium than the Pool rate; **OR**
- ☐ I am a Federally eligible individual. (See the attached brochure for the definition of a Federally eligible individual.)

What medical condition prompted you to apply for coverage with the Wyoming Health Insurance Pool? _____

When were you last treated for this condition? _____

RESIDENCY REQUIREMENTS

I certify that I currently occupy a dwelling in the State of Wyoming, intend to make Wyoming my home and meet a **MINIMUM OF TWO** of the following four requirements. (In the case of a minor child, this criteria must be met by the custodial parent.)

- ☐ I am registered to vote in the state of Wyoming.
- ☐ I have applied for or have received a Wyoming drivers license.
- ☐ My minor children attend school in the state of Wyoming. (If the applicant attends school, then he/she must attend school in the state of Wyoming).
- ☐ I have applied for or currently receive service in my name from a public utility at a dwelling within the state of Wyoming.

Please bill me: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Pre-authorized bank draft (Authorization Form below must be completed)

SEND NO MONEY NOW

Sign Here: _____ Date: _____
DO NOT PRINT Applicant's Signature (or Custodial Parent's)

AUTHORIZATION FORM FOR BANK DRAFT

Account Number _____ Date _____

I hereby authorize the _____ of _____
(Name of Bank) (Town)

Wyoming, to deduct monthly from my account, by draft of Electronic Funds Transfer, the current membership charges for the Wyoming Health Insurance Pool by Blue Cross Blue Shield of Wyoming. This authorization shall continue in effect until revoked by me in writing.

Bank Account Holder's Signature: _____

PLEASE NOTE: In order to process this request, we require that you enclose a voided check or deposit slip in order to ensure correct account handling.

Please attach a Creditable Coverage Certificate for the individual applying for coverage on this application.
List any health insurance plans that you have had or that have accepted you for coverage in the past 18 months.

1. Company name_____ Policy #_____
   Effective date ____/____/____ (MM/DD/YYYY) Cancellation date ____/____/____ (MM/DD/YYYY)
   Was this coverage ☐ Group ☐ Individual Was this coverage provided through your employer? ☐ Yes ☐ No

2. Company name_____ Policy #_____
   Effective date ____/____/____ (MM/DD/YYYY) Cancellation date ____/____/____ (MM/DD/YYYY)
   Was this coverage ☐ Group ☐ Individual Was this coverage provided through your employer? ☐ Yes ☐ No

If you or your spouse are currently employed, does the employer offer group health coverage? ☐ Yes ☐ No If yes, why are you not enrolled in this employer based plan?_____

Are you currently receiving Medicaid health care benefits? ☐ Yes ☐ No

Are you currently receiving both Medicare Part A and Part B benefits due to disability? ☐ Yes ☐ No

If so, list date of eligibility for Part A*_____ Part B* _____ *Please refer to your Medicare card

CERTIFICATIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS -- This program conforms to all Federal and State requirements regarding pre-existing condition exclusion periods including the definition of pre-existing conditions and the portability of pre-existing condition exclusion periods. Benefits will not be provided for pre-existing conditions for a period of twelve (12) months following the member's date of enrollment. Pre-existing conditions are those conditions for which medical advice, diagnosis, care or treatment was recommended or received in the six (6) months immediately preceding the enrollment date of coverage. Pregnancy existing on the enrollment date of coverage is considered a pre-existing condition.

In determining whether this pre-existing condition exclusion period applies to an eligible member, the Wyoming Health Insurance Pool will credit the time a member was previously covered by creditable coverage, provided there was not a significant break in coverage (90 days) from the previous creditable coverage. Waiting periods applicable under this individual health benefit plan shall not be considered in determining if a significant break in coverage has occurred, and will be credited toward any pre-existing condition exclusion period under this Agreement.

A. I understand upon acceptance of my application my coverage will become effective on the date established by the Wyoming Health Insurance Pool and that the Master Agreement, together with this application and attachments, if any, shall constitute my entire agreement with the Wyoming Health Insurance Pool.
B. I CERTIFY THAT THE STATEMENTS MADE ON THE APPLICATION ARE TRUE.
C. I REALIZE THAT ANY MISREPRESENTATION, FAILURE TO REVEAL MATERIAL INFORMATION ASKED FOR ON THIS APPLICATION, OR INCORRECT INFORMATION WILL RENDER THE CONTRACT NULL AND VOID, OR SUBJECT TO CANCELLATION, OR TO THE DISALLOWANCE OF COVERAGE FOR THE CONDITION OR THE PERSON ABOUT WHICH THE MISREPRESENTATION, OMISSION, OR INCORRECT INFORMATION OCCURRED AT THE SOLE DISCRETION OF THE WYOMING HEALTH INSURANCE POOL.
D. I hereby certify that I am not eligible for or enrolled in employer group health coverage under penalty of law.
E. I hereby apply for coverage with the Wyoming Health Insurance Pool under the terms and conditions stated in the Master Agreement, including the coordination of benefits provision.

THE FOREGOING HAS BEEN EXPLAINED AND I UNDERSTAND THE BENEFITS, LIMITATIONS AND EXCLUSIONS OF THE WYOMING HEALTH INSURANCE POOL, INCLUDING THE PRE-ADMISSION AUTHORIZATION REQUIREMENTS.

Sign Here:_____ Date: _____
DO NOT PRINT Applicant's Signature (or Custodial Parent's)

FOR AGENT'S USE ONLY

You must attach a copy of your Wyoming Insurance license to receive referral fee.

Agent Name_____ Agent Signature _____

Tax ID # _____ Agent Phone Number_____

Agent Address _____

Date _____

A State of Wyoming program administered by Blue Cross Blue Shield of Wyoming W04/2006

INDEMNIFICATION AGREEMENT

TO: The Bank Named on the Reverse Side.
In consideration of your participation in a plan which Blue Cross Blue Shield of Wyoming has put into effect by which amounts due on Wyoming Health Insurance Pool agreements are collected by checks drawn by Blue Cross Blue Shield of Wyoming on the accounts of persons who are responsible for these payments, BLUE CROSS BLUE SHIELD OF WYOMING DOES HEREBY AGREE THAT:
(1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn by Blue Cross Blue Shield of Wyoming on the account of such person, or arising out of the dishonor by you, whether with or without cause of intentionally or inadvertently, of any such check drawn by Blue Cross Blue Shield of Wyoming, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a Wyoming Health Insurance Pool contract the dues on which is sought to be collected by Blue Cross Blue Shield of Wyoming by any such check; and
(2) It will refund to you any amount erroneously paid by you on any such check if claim for the amount of such erroneous payments is made by you within twelve (12) months from the date of the check on which such erroneous payment was made.

BLUE CROSS BLUE SHIELD OF WYOMING

By: Tim J. Crilly, President and Chief Executive Officer

Affiliated Physician Program

Blue Cross Blue Shield of Wyoming is committed to finding ways to keep health care costs at an affordable level. That's why they are working with a growing number of dedicated Wyoming physicians to provide the most affordable and highest quality health care possible.

As participants in the Affiliated Physician Program, all member physicians have agreed to send your claims directly to Blue Cross Blue Shield of Wyoming, who will see that payment is made directly to the physician. This significantly reduces your involvement in the time-consuming claims process.

Through Blue Cross Blue Shield of Wyoming, the Affiliated Physician Program is an exclusive benefit to WHIP members only. We encourage you to choose an Affiliated Physician and start saving time today.

If you use non-affiliated physicians, you may have to submit your claims yourself. Always be sure to ask. **All claims should be sent to: Blue Cross Blue Shield of Wyoming; PO Box 2266; Cheyenne, WY 82003.**

The BlueCard®

More than 85% of all hospitals and physicians throughout the United States contract with independent Blue Cross Blue Shield organizations. Your identification card -- The BlueCard® -- links these health care providers to an electronic data system that quickly delivers your benefit information anywhere in the country.

Just show your identification card to any Blue Cross Blue Shield participating hospital or physician across the USA and receive the same special treatment you're accustomed to receiving right here in Wyoming.

Sunset

The Wyoming Health Insurance Pool is a State of Wyoming program and its continuance will be subject to legislative approval. Without legislative approval, this program will end on June 30, 2011.

Certificate of Creditable Coverage

When coverage under the WHIP is terminated, Blue Cross Blue Shield of Wyoming will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the affected member and/or dependents. Upon notification by the member of the ineligibility of a dependent, a Certificate of Creditable Coverage will be issued in a timely fashion thereafter. Certificates of Creditable Coverage may also be obtained from Blue Cross Blue Shield of Wyoming upon request within 24 months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through the Wyoming Health Insurance Pool.

Reasonable & Customary (R&C)

"Reasonable" is the fee which, in the opinion, of Blue Cross Blue Shield of Wyoming, is justified in the special circumstances of the particular case in question. "Customary" is the range of fees charged for individual procedures by Wyoming providers as represented in files maintained by Blue Cross Blue Shield of Wyoming. Benefits are paid according to the Reasonable and Customary fees in the state of Wyoming.

Federally Eligible Individual

A Federally eligible individual means an individual:

a) Who has had at least 18 months of creditable coverage as of the date the individual seeks coverage under the Pool; and
b) Whose most recent prior creditable coverage was under a group private or public health benefit plan; and
c) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or Medicaid, and who does not have other health insurance coverage; and
d) Whose most recent creditable coverage was not terminated based on nonpayment of premiums or fraud; and
e) Who, if offered, elected continuation coverage under a COBRA continuation provision or under a similar state program and exhausted such continuation coverage.

ATTACHMENT B

WYOMING HEALTH INSURANCE POOL

Monthly New Business Rates Effective 7/1/2006-6/30/2007

The Brown Plan		
Age	Male	Female
0 -12	192.30	192.30
13	193.70	213.50
14	194.90	237.00
15	196.40	263.00
16	198.00	289.30
17	199.10	315.40
18	200.60	340.60
19	202.10	364.50
20	203.60	386.30
21	205.10	405.70
22	206.50	424.00
23	210.80	440.90
24	215.10	456.40
25	219.90	470.10
26	224.20	481.80
27	229.00	491.50
28	236.40	498.80
29	244.10	503.80
30	251.90	503.80
31	260.10	503.80
32	268.30	503.80
33	277.00	503.80
34	285.90	503.80
35	294.90	503.80
36	306.10	503.80
37	317.40	503.80
38	329.20	503.80
39	341.60	503.80
40	354.20	503.80
41	367.60	507.10
42	382.10	518.20
43	400.80	531.80
44	420.20	546.00
45	441.00	560.30
46	462.70	575.10
47	485.40	590.30
48	511.70	612.00
49	539.80	634.50
50	569.10	657.60
51	600.20	681.70
52	633.00	707.00
53	671.10	728.40
54	711.40	750.90
55	754.10	773.90
56	799.70	797.50
57	847.70	821.90
58	890.10	851.90
59	934.40	882.90
60	981.10	915.00
61	1,030.10	948.30
62	1,081.40	982.70
63	1,120.40	1,012.40
64	1,160.80	1,042.50
65+	1,202.80	1,074.20

The Gold Plan		
Age	Male	Female
0 -12	274.10	274.10
13	276.10	304.30
14	277.80	337.70
15	279.90	374.90
16	282.10	412.40
17	283.70	449.50
18	285.90	485.40
19	288.10	519.50
20	290.10	550.60
21	292.20	578.20
22	294.40	604.20
23	300.40	628.30
24	306.50	650.30
25	313.30	669.80
26	319.60	686.50
27	326.30	700.30
28	336.90	710.80
29	347.80	717.90
30	359.00	717.90
31	370.60	717.90
32	382.50	717.90
33	394.80	717.90
34	407.40	717.90
35	420.30	717.90
36	436.10	717.90
37	452.40	717.90
38	469.10	717.90
39	486.80	717.90
40	504.80	717.90
41	523.80	722.70
42	544.50	738.30
43	571.20	757.90
44	599.00	778.10
45	628.50	798.30
46	659.50	819.50
47	691.70	841.20
48	729.20	872.10
49	769.30	904.10
50	811.00	937.10
51	855.30	971.50
52	902.00	1,007.40
53	956.30	1,037.90
54	1,013.80	1,069.90
55	1,074.70	1,102.80
56	1,139.70	1,136.50
57	1,208.00	1,171.30
58	1,268.50	1,214.00
59	1,331.50	1,258.20
60	1,398.00	1,304.00
61	1,467.90	1,351.30
62	1,541.00	1,400.40
63	1,596.60	1,442.60
64	1,654.10	1,485.50
65+	1,714.10	1,530.70

Billing Options (you may choose between 1 or 2):

1. We will send you a bill in the mail on the schedule you choose:
   Monthly: the rate is listed above
   Quarterly: the rate is three times the monthly rate listed above
   Semi-annually: the rate is six times the monthly rate listed above

2. We will automatically withdraw the monthly premium from your checking account each month. A voided check or deposit slip is required for proper account handling.

Attachment C – Specified Illness List for Eligibility for the Traditional or Premium Assistance Plans under the Montana Comprehensive Health Association insurance pool.

Acquired Immune Deficiency Syndrome (AIDS)	**Hydrocephalus**
Alzheimer's Disease	**Hypogammaglobulinemia**
Amyloidosis	**Leukemia (within 12 years)**
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	**Lupus Erythmatosus Systemic**
Aortic Aneurysm	**Malignant Tumor (list specific tumor)**
Aplastic Anemia	**Metastatic Cancer (within 12 years)**
Ascites	**Morbid Obesity**
Banti's Disease	**Multiple Sclerosis**
Berger's Disease	**Muscular Dystrophy**
Cardiac Asthma	**Myasthenia Gravis**
Cardiomyopathy	**Neurofibramatosis**
Charcot-Marie-Tooth	**Osteogenesis Imperfecta**
Chronic Pancreatitis	**Pacemaker**
Chronic Renal Failure	**Peutz-Jegher's Syndrome**
Cirrhosis of the Liver	**Polycystic Kidney Disease**
Congestive Heart Failure	**Primary Pulmonary Hypertension**
Coronary Artery Disease (to include: Bypass surgery, Angioplasty, Myocardial Infarction)	**Psychotic Disorders**
Crohn's Disease	**Tabes Dorsalis (Locomotor Ataxia)**
Cystemegalorisus	**Tetralogy Of Fallot**
Cystic Fibrosis	**Transcient Ischemic Attack (TIA)**
Diabetes Type I	**Tuberculosis**
Fanconi's Syndrome	**Von Willebrand's Disease**
Hansen's Disease (Leprosy)	**Wilson's Disease**
Hemophilia (A, B, or C)	**Wegener's Granulomatosis**
Hepatitis C	
History of Major Organ Transplant	**Autism**
Huntington's Chorea	**Sarcoidosis**

Source: Montana Comprehensive Health Association website, www.mthealth.org.

Additional Benefits

Healthy Generations

Healthy Generations provides education, support, and early identification of risks to help expectant mothers achieve a full term pregnancy. This service is voluntary and available at no additional cost to MCHA members.

New Member Contact

As a new member to MCHA, you will be contacted by an APS Care Coordinator, a registered nurse, who will explain programs available to you and conduct a brief health risk assessment. You may have direct access to that Care Coordinator should you need them in the future.

Some common services for which coverage is not provided are:

- ☞ Eyeglasses
- ☞ Hearing Aids
- ☞ Treatment for Chemical Dependency
- ☞ Treatment for Mental Illness (except Severe Mental Illness)

For Information on MCHA:

- Call the Administrator, Blue Cross and Blue Shield of Montana at 444-8537 or 1-800-447-7828, Extension 8537, or any of the district offices of Blue Cross and Blue Shield of Montana, or
- Call any health insurance producer/agent.
- Call the Montana Department of Insurance at 1-800-332-6148 or 444-2040.

ATTACHMENT D

NUMBERS TO CALL

Administrator
Blue Cross and Blue Shield of Montana
1-800-447-7828, Extension 8537
or
444-8537

Montana Department of Insurance
1-800-332-6148 or 444-2040

or visit the MCHA Website at:

www.mthealth.org

Administered By:

Blue Cross and Blue Shield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

BCBSMT provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

MCHA TRAD Brochure (01/2006)

MONTANA COMPREHENSIVE HEALTH ASSOCIATION

Can't get medical insurance for health reasons?

Call the MCHA

Administered by Blue Cross and Blue Shield of Montana

HAVE YOU BEEN DENIED MEDICAL INSURANCE OR HAD LIMITATIONS PLACED ON YOUR POLICY BECAUSE OF YOUR HEALTH?

The Montana Comprehensive Health Association (MCHA) may help.

What is MCHA?

The MCHA was established by the Montana Legislature to make comprehensive health insurance benefits available to high-risk individuals regardless of their physical condition.

The continued viability of the program is ensured through various funding mechanisms, which include the premiums paid by enrollees on the plan, and assessments made to the health insurers operating in the state.

Eligibility

You may be eligible for this plan if:

1. You are a resident of the state of Montana for at least 30 days; and
2. You have been rejected or offered a restrictive rider by two insurers within the last six months or have one of the specified major illnesses; and
3. You are not eligible for any other health insurance coverage including Medicaid; or, you have comparable coverage but are paying or have received a notice of a premium rate that is more than 150% of the average premium rate used to calculate MCHA premium rates.

NOTE: If you work for an employer who has between 2 and 50 employees, you may now be eligible to join your employer's group health program without having to show proof of good health. For more information about small group coverage, please call the Montana Department of Insurance at 1-800-332-6148.

Preexisting Condition Limitation

No payment will be made for treatment of <u>any</u> preexisting condition, including pregnancy, until you have been continuously covered under this Plan for 12 months. This preexisting condition limitation does not apply:

1. to newborn children or children placed for adoption; or
2. Creditable coverage may be given if:
   - coverage was not voluntarily canceled by the applicant
   - application for this plan is made within 30 days of the last day of your previous coverage
   - all other options for health insurance, including COBRA or state continuation, have been exhausted

If you become insured by MCHA, read your contract carefully.

Participating Provider Network

Participating Providers accept the allowable fee as their full reimbursement, so Plan payment, deductible, and co-payment is their full reimbursement. **They will not bill you for charges in excess of the allowable fee for covered services.** Payment for services of nonparticipating providers is made directly to you. **These providers may bill you for charges above the allowable fee in addition to deductible and co-payment.**

Benefits

Three options for coverage:

Deductible Option	Copay	Maximum Annual Deductible & Copay Limit
$1,000	80/20	$5,000.
$2,500	80/20	$6,000.
$5,000	80/20	$7,500.
Lifetime Maximum: $1,000,000.		

Some examples of services for which coverage is provided are:

- ☞ Inpatient Hospital care
- ☞ Convalescent Home - 60 Days/Year
- ☞ Outpatient Hospital care
- ☞ Office Visits
- ☞ Surgery and Anesthesia
- ☞ X-ray and Lab
- ☞ Immunizations
- ☞ Radiation Therapy and Chemotherapy
- ☞ Ambulance
- ☞ Oxygen
- ☞ Durable Medical Equipment
- ☞ Prosthetics
- ☞ Diabetes Education
- ☞ Newborn and Adopted Children coverage for First 31 Days
- ☞ Well-Child Care through 2 years of age
- ☞ Home Health Care - 180 Visits/Year
- ☞ Mammography
- ☞ Maternity
- ☞ Transplants–$150,000 Lifetime Benefit
- ☞ Inpatient Rehabilitation Therapy
- ☞ Prescription Drug Coverage
- ☞ Severe Mental Illness (certain diagnoses only)

This is not a contract. This brochure is only a brief outline of the important benefits of the MCHA plan.

*Prescription Drug Benefit**

<u>(not available with Medicare Carve Out Option)</u>

Deductible $0

Pharmacy Benefit for up to 34 day supply:

Generic $10

Brand Name Formulary
$35+20% of remaining cost
Maximum copay per script $200

Brand Name Non-Formulary
$50+30% of remaining cost
Maximum copay per script $300

Mail Service Program for up to 90 day supply:

Generic $20

Brand Name Formulary
$70+20% of remaining cost
Maximum copay per script $400

Brand Name Non-Formulary
$100+30% of remaining cost
Maximum copay per script $600

Self-Audit Program

You may be eligible to receive 50 percent of the savings up to $1,000 if you detect and identify an error on your bill that has been processed by the lead carrier.

Individual Assistance Program

A little help sometimes goes a long way. Short-term counseling for any personal problems for you and your immediate family members is available at no cost to you through the IAP. Help is available for stress, depression, grief, mental issues, parenting, finances, drug and alcohol abuse, and other problems. 24-hour crisis counseling is also available.

Medicare

If you are eligible for Medicare A & B, you may qualify for this plan at a reduced rate. If you have coverage with Medicare, your MCHA plan will be your secondary coverage. Once Medicare has processed your claim, MCHA will process according to your MCHA benefits. MCHA will coordinate with Medicare and not pay more than the balance remaining after Medicare's payment.

*<u>Prescription drugs are not covered on the Medicare Carve Out Option</u>

ATTACHMENT E

MONTANA COMPREHENSIVE HEALTH ASSOCIATION
TRADITIONAL PLAN
OPTION 1000
SCHEDULE OF PREMIUMS

EFFECTIVE JANUARY 1, 2006

$1,000 DEDUCTIBLE

Age	Premium	Age	Premium
0-17	$178	41	$467
18	$308	42	$480
19	$309	43	$497
20	$312	44	$515
21	$313	45	$533
22	$314	46	$553
23	$317	47	$573
24	$319	48	$598
25	$321	49	$625
26	$325	50	$653
27	$327	51	$682
28	$334	52	$712
29	$342	53	$739
30	$349	54	$764
31	$354	55	$792
32	$363	56	$821
33	$374	57	$850
34	$385	58	$874
35	$396	59	$898
36	$409	60	$923
37	$422	61	$949
38	$433	62	$976
39	$444	63	$989
40	$456	64 & over	$1,001

Medicare Carveout

0 – 17	$54
18 – 65 and over	$145

MONTANA COMPREHENSIVE HEALTH ASSOCIATION
TRADITIONAL PLAN
OPTION 2500
SCHEDULE OF PREMIUMS

EFFECTIVE JANUARY 1, 2006

$2,500 DEDUCTIBLE

Age	Premium	Age	Premium
0-17	$150	41	$396
18	$261	42	$406
19	$261	43	$421
20	$264	44	$436
21	$265	45	$452
22	$266	46	$468
23	$268	47	$485
24	$270	48	$506
25	$272	49	$530
26	$275	50	$553
27	$277	51	$578
28	$283	52	$603
29	$289	53	$626
30	$295	54	$647
31	$300	55	$671
32	$307	56	$695
33	$317	57	$720
34	$326	58	$740
35	$335	59	$761
36	$346	60	$782
37	$357	61	$804
38	$366	62	$827
39	$376	63	$838
40	$386	64 & over	$848

MONTANA COMPREHENSIVE HEALTH ASSOCIATION
TRADITIONAL PLAN
OPTION 5000
SCHEDULE OF PREMIUMS

EFFECTIVE JANUARY 1, 2006

$5,000 DEDUCTIBLE

Age	Premium	Age	Premium
0-17	$104	41	$274
18	$180	42	$281
19	$181	43	$291
20	$183	44	$301
21	$183	45	$312
22	$184	46	$324
23	$185	47	$335
24	$187	48	$350
25	$188	49	$366
26	$190	50	$383
27	$192	51	$399
28	$196	52	$417
29	$200	53	$433
30	$204	54	$447
31	$208	55	$464
32	$213	56	$481
33	$219	57	$498
34	$225	58	$512
35	$232	59	$526
36	$240	60	$541
37	$247	61	$556
38	$253	62	$571
39	$260	63	$579
40	$267	64 & over	$586

Premiums for the single Policyholder are payable according to the above schedule. The age of the Policyholder determines the premiums payable. When your age changes (e.g., turn 50), your rates will be increased to the next band at the next rate renewal increase. Rates are subject to change each January.

To determine your premium, find the correct age band. Your age band is your age as of January 1, 2006.

MONTANA COMPREHENSIVE HEALTH ASSOCIATION
PORTABILITY PLAN
OPTION 1000

SCHEDULE OF PREMIUMS

EFFECTIVE JANUARY 1, 2006
$1,000 DEDUCTIBLE

Age	Premium	Age	Premium
0-17	$187	41	$492
18	$324	42	$505
19	$325	43	$523
20	$329	44	$542
21	$329	45	$562
22	$331	46	$582
23	$333	47	$603
24	$336	48	$630
25	$338	49	$659
26	$342	50	$688
27	$345	51	$718
28	$352	52	$750
29	$360	53	$778
30	$367	54	$804
31	$373	55	$835
32	$382	56	$864
33	$394	57	$895
34	$405	58	$921
35	$417	59	$946
36	$431	60	$973
37	$444	61	$999
38	$456	62	$1,028
39	$467	63	$1,042
40	$480	64 & over	$1,054

MONTANA COMPREHENSIVE HEALTH ASSOCIATION
PORTABILITY PLAN
OPTION 2500

SCHEDULE OF PREMIUMS

EFFECTIVE JANUARY 1, 2006
$2,500 DEDUCTIBLE

Age	Premium	Age	Premium
0-17	$125	41	$327
18	$216	42	$336
19	$216	43	$348
20	$219	44	$360
21	$219	45	$373
22	$220	46	$387
23	$222	47	$401
24	$223	48	$418
25	$225	49	$438
26	$227	50	$457
27	$229	51	$478
28	$234	52	$499
29	$239	53	$517
30	$244	54	$535
31	$248	55	$555
32	$254	56	$575
33	$262	57	$595
34	$269	58	$612
35	$277	59	$629
36	$286	60	$647
37	$295	61	$664
38	$303	62	$683
39	$311	63	$693
40	$319	64 & over	$701

MONTANA COMPREHENSIVE HEALTH ASSOCIATION
PORTABILITY PLAN
OPTION 5000

SCHEDULE OF PREMIUMS

EFFECTIVE JANUARY 1, 2006
$5,000 DEDUCTIBLE

Age	Premium	Age	Premium
0-17	$109	41	$288
18	$190	42	$296
19	$190	43	$306
20	$192	44	$317
21	$193	45	$329
22	$194	46	$341
23	$195	47	$353
24	$196	48	$369
25	$198	49	$386
26	$200	50	$403
27	$202	51	$421
28	$206	52	$439
29	$210	53	$456
30	$215	54	$471
31	$218	55	$489
32	$224	56	$506
33	$231	57	$524
34	$237	58	$539
35	$244	59	$554
36	$252	60	$570
37	$260	61	$585
38	$267	62	$602
39	$273	63	$610
40	$281	64 & over	$617

Premiums for the single Policyholder are payable according to the above schedule. The age of the Policyholder determines the premiums payable. When your age changes (e.g., turn 50), your rates will be increased to the next band at the next rate renewal increase. Rates are subject to change each January.

To determine your premium, find the correct age band. Your age band is your age as of January 1, 2006.

MONTANA COMPREHENSIVE HEALTH ASSOCIATION
PREMIUM ASSISTANCE PROGRAM
SCHEDULE OF PREMIUMS

EFFECTIVE JANUARY 1, 2006

$1,000 DEDUCTIBLE
45% SUBSIDY

Age	Premium	Age	Premium
0–17	$97.90	41	$256.85
18	$169.40	42	$264.00
19	$169.95	43	$273.35
20	$171.60	44	$283.25
21	$172.15	45	$293.15
22	$172.70	46	$304.15
23	$174.35	47	$315.15
24	$175.45	48	$328.90
25	$176.55	49	$343.75
26	$178.75	50	$359.15
27	$179.85	51	$375.10
28	$183.70	52	$391.60
29	$188.10	53	$406.45
30	$191.95	54	$420.20
31	$194.70	55	$435.60
32	$199.65	56	$451.55
33	$205.70	57	$467.50
34	$211.75	58	$480.70
35	$217.80	59	$493.90
36	$224.95	60	$507.65
37	$232.10	61	$521.95
38	$238.15	62	$536.80
39	$244.20	63	$543.95
40	$250.80	64 & over	$550.55

Medicare Carveout

0–17	$29.70
18 & Over	$79.75

Premiums for the single Policyholder are payable according to the above schedule. The age of the Policyholder determines the premiums payable. When your age changes (e.g., turn 50), your rates will be increased to the next band at the next rate renewal increase. Rates are subject to change each January.

To determine your premium, find the correct age band. (Your age band is your age as of January 1, 2006.) Your premium will be subsidized 45%.