HMO CONVERSION PLAN

For Connecticut Residents

Health Reinsurance Association

100 Great Meadow Road, Suite 704

Wethersfield, CT 06109

1-800-842-0004

www.hract.org

Who is Health Reinsurance Association (HRA)?

The Connecticut Health Care Act of 1975 created the Health Reinsurance Association (HRA) to make available to eligible individuals in Connecticut a comprehensive health care plan designed to help meet medical costs of non-occupational injuries and diseases.

HRA is a non-profit association comprised of all private insurance companies and HMOs that provide health insurance in Connecticut.

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Who is Eligible?

- Any resident of Connecticut under the age of 65.
- You have had continuous coverage for at least 12 months.
- Your application is received in our office within 120 days of the end of your prior health insurance plan due to voluntary loss of coverage or 150 days of the end of your prior health insurance plan due to involuntary loss of coverage. The HRA plan will begin coverage the 1st of the month following receipt of a completed application.

. Eligible Dependents Are:

- Your Spouse
- Your unmarried children (biological or adoptive) under nineteen years of age (twenty-three if a full time student attending an accredited institution of higher learning) who depends on you for support.
- Your disabled dependent children, regardless of age with proper documentation.
- Any other unmarried child (biological or adoptive) under nineteen years of age (twenty-three if a full time student attending an accredited institution of higher learning) who depends on you for support and lives with you in a regular parent child relationship.

Qualifying Coverage – means the following

- Any group health insurance plan, group insurance arrangement, or self-insured plan covering a group, or
- Medicare or Medicaid, or
- An individual health insurance plan that provides benefits which are actuarially equivalent to or exceeding the benefits provided under a small employer health care plan, as defined in section 38a-564, whether issued in this state or any other state.

Pre-existing Conditions

A pre-existing condition is a medical condition for which medical advice or treatment was recommended or given within 6 months prior to coverage under this plan

Conversion plans: If you are eligible for the conversion and were under prior Qualifying Coverage for 12 months or more, there is no waiting period for pre-existing medical conditions.

If you have had less then 12 months of continuous Qualifying Coverage, HRA will credit that time towards a 12 month pre-existing waiting period.

Effective Date: The effective date will be the 1st of the month following receipt of a completed application

Plan Options and How to Choose

Options: If you are eligible for a conversion plan you may choose any of the plans offered through HRA: HMO, PPO or CT Special Health Care Plan.

If you are not eligible under the conversion plan, contact HRA for other options that may be available to you.

How to Choose: This brochure gives you general information about managed care plans, plus highlights on how the plan works and what it covers. A directory of the providers for each plan may be obtained through HRA. See the Connecticut Special Health Care Conversion Plan brochure or PPO Conversion Plan brochure for details on those plans.

Managed care plans all have a network of providers (doctors, hospitals and other medical services). These networks only admit providers that meet the plan's quality standards. Network providers also agree to work with the network medical team to provide the most appropriate care.

How HMOs Plans Work

HMOs, another type of managed care plan, also put you in touch with affordable care from qualified providers.

Independent Practice Models (IPA) – such as Health Net - are comprised of independent providers working out of their own offices. In general, here is how these HMOs work:

1. Care from a Primary Care Physician – You choose any primary care physician from the HMO's directory to be your main source of care. You do not need a referral from your primary care physician in order to visit a specialist in the HMO network.
2. Low Cost and No Claim Forms – At the time of service you make a small payment, called a co-payment. Any medically necessary treatment you receive from HMO providers is covered by the plan. There are not claim forms to fill out.
3. You Must Use Network Providers – If you go to a provider that is not part of the HMO network, your expenses are not covered and you must pay the entire cost of care out of your own pocket.

PLAN BENEFIT DESCRIPTION
HMO through Health Net of the Northeast

A listing of providers (Advantage Platinum plan) can be found at www.health.net

HRA's medical plan provides up to $1,500,000.00 in benefits during each covered person's lifetime.

Out of Pocket Maximum- Only out-of-pocket expenses for covered services count toward the out-of-pocket maximum.

$5,000 per Individual **$10,000 per family**

Annual Deductibles- The amount you pay out-of-pocket for covered services before the plan begins to reimburse you. **None**

Physicians Services	
Office visits	$25 co-payment per visit
Inpatient surgery	No cost (Plan pays 100%)
Outpatient surgery	$25 co-payment per visit
Hospital Services	
Inpatient	$250 Co-pay per day to a Maximum $1,000 per Inpatient Hospital Admission
Outpatient	$25 co-payment
Emergency Room	$75 co-payment
Skilled Nursing Facility	$250 Co-pay per day to a Maximum $1,000 per Inpatient Hospital Admission 120 days maximum. No Co-pay if confinement immediately follows a hospitalization
Occupation/Speech Therapy	$25 co-payment per visit (Plan pays for 30 visits per course of prescribed treatment)
X-ray and Lab Exams	No Cost (Plan pays 100%)
X-ray Therapy	$25 co-payment per visit
Eye Exams	$25 co-payment per visit
Ambulance	No cost if it is an emergency and you are admitted to the hospital.
Pediatric Well Care	No cost up to age 6. Including immunizations
Other Routine Exams	$25 co-payment per visits
Immunizations	No Cost (Plan pays 100%)

Benefit	Coverage
Maternity including Pre/Postnatal Care	No cost for outpatient visits
Hospice Care	No cost if you are confined (Plan pays 100%)
Home Health Care	$25 co-payment per visit
Alcohol/Substance Abuse –	Inpatient: 45 days maximum per calendar year $250 Co-pay per day to a Maximum $1,000 per Inpatient Hospital Admission Outpatient: $40 co-payment per visit $1000 per calendar year maximum
Mental Health	Inpatient: 60 days maximum per calendar year $250 Co-pay per day to a Maximum $1,000 per Inpatient Hospital Admission Outpatient: $40 co-payment per visit $2000 per calendar year maximum
Partial Hospitalization	120 sessions maximum per calendar year. (2 sessions count as 1 inpatient day) $40 co-payment per session for first 40 sessions
Outpatient Prescriptions	Three Tier Co-payment $10/$25/$40. Must be FDA approved.
Durable Medical	$400 co-payment per item
Prostheses	$400 co-payment per item. No cost for internal prostheses. (Plan pays 100%)
Non-notification Penalty	The amount you pay if you do not receive pre-approval for certain services. See Contract

Managed Care Terms

Co-payment: In the HMO plan, this is the amount you pay at time of service.

Health Maintenance Organization (HMO): An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.

Network: A group of managed care providers that agrees to treat plan members.

Pre-existing Condition: A pre-existing condition is a medical condition for which medical advice or treatment was recommended or given within 6 months prior to coverage under this plan. Under the Health Reinsurance Association Portability plans, pregnancy is not considered a pre-existing condition.

Primary Care Physician: A physician the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics.

Provider: A doctor, hospital or other medical service that delivers care.

Referral: The recommendation by a physician and/or health plan for a member to receive care from a different physician or facility.

QUESTIONS?
PLEASE CALL HRA AT 1-800-842-0004
MONDAY – FRIDAY 9:00AM TO 4:00PM

Please send completed applications and applicable premium to:

Health Reinsurance Association (CT)
100 Great Meadow Road, Suite 704
Wethersfield, CT 06109

2009 HRA PLAN RATES

Monthly Premium Rates per Individual
HMO Conversion Plan

Attained Age	Male	Female	Child(ren)
<30	$417.74	$812.99	$611.12
30-34	$505.36	$854.62	
35-39	$555.89	$841.68	
40-44	$667.03	$881.12	
45-49	$824.46	$959.40	
50-54	$1,086.43	$1,102.14	
55-59	$1,421.83	$1,287.68	
60-64	$1,814.43	$1,537.03	

Please note: When you or any covered family member has a birthday that moves you to the next age bracket, the rate will change the month after the birthday occurs.

How to figure out your cost of coverage

1. Go to the above rate chart and get a rate for your coverage based on you age and gender.
2. Get rates for other family members to be covered based on their ages and genders. (The rate shown for “child(ren)” is a flat rate for all your children, no matter how many are covered.)
3. Add together all the rates for your family members. This is your monthly cost of coverage.

HMO Plan Conversion Application
Health Reinsurance Association (CT)
Health Net

Section I

Applicant's Name		Social Security Number	Date of Birth	Marital Status
Home Address (Street)		Town	State & Zip Code	Connecticut Resident ☐ Yes ☐ No
Billing Address (if different from Home Address)		Town	State & Zip Code	
Applicant's Gender ☐ Male ☐ Female	Home Phone Number	Work Phone Number	Email Address	

List Names of All Eligible Family Members

Spouse's Name	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female	Connecticut Resident ☐ Yes ☐ No

For dependent child(ren) between the ages of 19 & 23, full time student verification must accompany application. For disabled dependent child(ren) over age 19, a letter from Social Security or court papers verifying disability must accompany application.

Child's Name	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female	Full Time Student ☐ Yes ☐ No	CT Resident ☐ Yes ☐ No
Child's Name	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female	Full Time Student ☐ Yes ☐ No	CT Resident ☐ Yes ☐ No
Child's Name	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female	Full Time Student ☐ Yes ☐ No	CT Resident ☐ Yes ☐ No
Child's Name	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female	Full Time Student ☐ Yes ☐ No	CT Resident ☐ Yes ☐ No

Section II

Please answer the following questions.

1. Do you have coverage under a Group insurance that will be ending? ☐ Yes ☐ No If yes, please attach verification of coverage. If you will have coverage in addition to HRA, please complete the table on the next page.
2. Do you have coverage under Medicaid or Medicare Part A and/or Part B that will be ending? ☐ Yes ☐ No If yes, attach verification of coverage. If you will have coverage in addition to HRA please complete the table on the next page.
3. Do you have coverage under an Individual insurance that will be ending? ☐ Yes ☐ No If yes, attach verification of coverage. If you will have coverage in addition to HRA please complete the table on the next page and please provide us with a copy of your current policy.
4. Are you submitting this application within 120 days (due to voluntary loss of coverage) of the termination date of your previous plan? ☐ Yes ☐ No
5. If you answered "No" to #4, are you submitting this application with 150 days (due to involuntary loss of coverage) of the termination of your previous plan? ☐ Yes ☐ No

If you have answered "No" to both questions 4 & 5, you do not qualify for our Conversion plans. Please contact our office for our Individual plan options.

Table of Other Coverage

(To be completed only if you will have other insurance at the same time you have HRA insurance)

Name of Carrier	Policy Number	Effective Date	Termination Date	Type of Coverage
				☐ Group ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Individual
				☐ Group ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Individual
				☐ Group ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid ☐ Individual

Section III

I hereby represent that all of the above answers are true and correct to the best of my knowledge and belief and form the basis upon which an individual policy may be issued. If application is being signed by an Executor or Power of Attorney, please provide appropriate documentation.

Applicant's Signature	Date

Endorsed By Health Reinsurance Association (Connecticut)

Effective Date of Coverage	By Date

Please provide us with the following information, if a licensed insurance agent assisted in the completion of this application

Agency or Agent Name	License Number
Address	Tax ID Number

Please send completed application, applicable monthly premium, and verification of coverage to:

Health Reinsurance Association
100 Great Meadow Road, Suite 704
Wethersfield, CT 06109

Check or Money Order should be made payable to "Health Reinsurance Association"

Check List for Submitting Application

In order for an application to be processed, you must include all of the required documentation. It is your responsibility to submit a completed application and obtain all necessary documentation. If two or more of the items are missing, your application will be returned.

A complete application consists of the following three items:

1. APPLICATION FOR COVERAGE

    - Complete entire application. Do not leave any areas blank. If section does not apply, write "NA" in that section.
    - Information will not be transferred from supporting documentation to application
    - Original signature of applicant is required.

2. PREMIUM PAYMENT

    - You must include premium for the first month with your application.
    - Make checks payable to "Health Reinsurance Association"

3. PROOF OF PRIOR COVERAGE: Applicants must provide a Certificate of Creditable Coverage or other proof of coverage if they have lost insurance within the last 120 days if health insurance was voluntarily terminated or 150 days if health insurance was involuntarily terminated.

    - Certificate of Creditable Coverage which documents an effective date and a termination date.
    - If you do not have a Certificate, you can provide a letter from the following to verify coverage.
        1. Former Employer if coverage was group insurance
        2. The State or Federal government if coverage was Medicaid or Medicare.
        3. Your insurance agent – agent must include, name, address, phone number, and tax id number to verify valid licensed agent.

    Please note with the alternative methods for verification of coverage effective **and** termination dates must be included.

Mail this application and all required documentation to: Health Reinsurance Association
100 Great Meadow Road, Suite 704
Wethersfield, CT 06109