PPO 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 the 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 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 each 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 Plan brochure for details on the Special Health Care Plan.

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.

As a member, you can take advantage of the resulting low costs and reduce your out-of-pocket costs by always seeking care from these network providers.

How PPO Plans Work

PPO managed care plans give you access to quality care at a lower cost, plus the ability to make your own health care decisions. In general, here is how a PPO works:

1. Low Cost Care and No Claim Forms - When you need care, you are free to visit any network provider listed in your PPO directory. You pay lower out-of-pocket costs when you get service because of negotiated discounts with network providers. The plan reimburses your other costs at the highest level and your provider fills out the claim forms for you.
2. Freedom to See Other Providers- You have the option of visiting providers that are not listed in your directory. In this case, the plan reimburses your costs at a lower level, and you pay more out-of-pocket towards the cost of care. You also must fill out the claim forms.
3. Approval Required in Special Cases – When your doctor recommends certain types of treatment, you must call the medical advisors at Patient Advocate for approval. If you do not call, or your treatment is not approved, you benefits will be paid at a lower level.

PLAN BENEFIT DESCRIPTION

PPO Through United HealthCare

A listing of providers (Options PPO plan) can be found at www.unitedhealthcare.com

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.

In-Network	**$7,500 per Individual**	**$15,000 per family**
Out of Network	**$15,000 per Individual**	**$30,000 per family**

Annual Deductibles- The amount you pay out-of-pocket for covered services before the plan begins to reimburse you.

In-Network	**$1,500 per Individual**	**$3,000 per family**
Out of Network	**$3,000 per Individual**	**$6,000 per family**

Physicians Services	**In-Network**	**Out of Network**
Office visits	80% after deductible	60% after deductible
Inpatient surgery	80% after deductible	60% after deductible
Outpatient surgery	80% after deductible	60% after deductible
Hospital Services		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Emergency Room	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible 120 day maximum	60% after deductible 120 day maximum
Occupation/Speech Therapy	80% after deductible	60% after deductible
X-ray and Lab Exams	80% after deductible	60% after deductible
X-ray Therapy	80% after deductible	60% after deductible
Eye Exams	80% after deductible Routine eye exams not covered (Except for Children under 17)	60% after deductible Routine eye exams not covered (Except for children under 17)

Ambulance	80% after deductible	60% after deductible
Pediatric Well Care Including immunizations	100% No deductible required	100% No deductible required
Other Routine Exams	80% after deductible	60% after deductible
Immunizations	80% after deductible	60% after deductible
Maternity including Pre/Postnatal Care	80% after deductible Deductible waived for prenatal care	60% after deductible Deductible waived for prenatal care
Hospice Care	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible

Alcohol/Substance Abuse – 80% after deductible 60% after deductible
Inpatient: 45 days maximum per calendar year

Outpatient: $1000 per calendar year maximum

Mental Health 80% after deductible 60% after deductible
Inpatient: 60 days maximum per calendar year

Outpatient: $2000 per calendar year maximum

Partial Hospitalization 80% after deductible 60% after deductible
120 sessions' maximum per calendar year.
(2 sessions count as 1 inpatient day)

Prescriptions $250 Deductible then 3 Tier co-pay of 10/25/40

Durable Medical	80% after deductible	60% after deductible
Prostheses	80% after deductible	60% after deductible

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 PPO plan, this is the amount you pay for prescriptions once the prescription deductible is met.

Deductible: The amount you pay before the PPO plan benefits can begin.

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

Out-of-Network: Providers that are not in the managed care network. The level of benefits you receive when you visit providers that are not in the PPO network.

Patient Advocate: Trained nurses and doctors who offer treatment options to PPO members facing certain kinds of procedures. To avoid penalty costs, you must call them and follow their advice.

Pre-existing Condition: A medical condition that you had (or one of which you sought treatment or advice) within the six months prior to joining the HRA plan. A pregnancy that existed on the effective date of your HRA coverage is not considered a pre-existing condition.

Preferred Provider Organization: A type of managed care plan that offers care through a network of medical providers. It allows you to seek care from out-of-network providers if you pay a greater portion of the cost of care out of your pocket.

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
PPO Conversion Plan

Attained Age		**Male**		**Female**		**Child(ren)**
<30		$324.61		$631.74		$474.87
30-34		$392.69		$664.09		
35-39		$431.95		$654.03		
40-44		$518.32		$684.68		
45-49		$640.64		$745.50		
50-54		$844.21		$856.42		
55-59		$1,104.84		$1,000.59		
60-64		$1,409.90		$1,194.35		

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.

PPO Plan Conversion Application
Health Reinsurance Association (CT)
United Health Care

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

OVER

Table of Other Coverage
(To be completed only if you will have other coverage 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 shall 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's Name	License Number
Address	Tax Id Number

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