

CONNECTICUT'S SPECIAL HEALTH CARE CONVERSION PLAN

For Connecticut Residents



This Conversion Plan is based on Connecticut Statute,
Chapter 700c, Section 38a-556 and is only
Available through HRA

Health Reinsurance Association
100 Great Meadow Road, Suite 704
Wethersfield, CT 06109
1-800-842-0004

www.hract.org

Established to Serve the Needs of Connecticut Residents

The Health Reinsurance Association (HRA) provides health insurance for eligible individuals. The HRA Special Health Care Plans provide comprehensive medical benefits for 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.

TABLE OF CONTENTS

Who Is Eligible	Page 1
Definitions	Page 1
<u>Eligible Dependents</u>	
<u>Pre-existing Conditions</u>	
<u>Effective Date of Policy</u>	
How The Special Health Care Plan Works	Page 2
Benefit Description	Pages 3
Exclusions	Page 4
Renewal and Termination Information	Page 5
Health Reinsurance Association Contact Information	Page 5
Special Health Care Conversion Plan Rate Sheet	Page 6
Special Health Care Conversion Plan Application	Page 7 & 8
Check List for Submitting Application	Page 9

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.
- You are eligible for one of the Special Health Care plans depending on your adjusted gross income and the size of your family.
- To qualify for the Low Income Plan your adjusted gross income from the prior year must be equal to or less than 300% of the federal poverty level. (See page 6) These amounts will be updated annually. The insured's eligibility to qualify for the low income or non low income plan will be certified each year, by your prior year Federal Tax return.
- You must submit the Federal Tax return with your application as verification of low-income eligibility.

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

Definition: Pre-existing condition - 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 plan and were covered under prior Qualifying Coverage for 12 months or more, there is no waiting period for pre-existing medical conditions.

If you have had less than 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.

Health Benefits: HRA's medical plan provides up to \$1,500,000 in benefits during each covered person's lifetime.

How The Special Health Care Plan Works

Benefit Amount

This plan will pay 75% of the Medicare Reimbursement Level (established for medical services) after the covered person pays the calendar year deductible. The Medicare Reimbursement Level is based on the amount that could be paid under the Federal Medicare Program.

For low-income individuals, health care providers in Connecticut must accept 75% of the Medicare Reimbursement Level as full payment. No balance can be billed to the covered person above the 75% benefit payment. The covered person is responsible for the payment of the calendar year deductible; only those expenses up to 75% of the Medicare Reimbursement Level of Covered Medical Expenses will be used toward satisfying the deductible.

Calendar Year Deductible

	<u>Individual</u>	<u>Family</u>
Low-Income	\$200	\$400
Non-Low Income	\$500	\$1000

Only those expenses up to 75% of the Medicare Reimbursement Level of Covered Medical Expenses will be used toward satisfying the deductible.

Reimbursement Example

	<u>Low- Income</u>	<u>Non-Low Income</u>
1. Amount Billed by Medical Provider	\$1000	\$1000
2. Usual and Customary Charge	\$900	\$900
3. Medicare Reimbursement Level	\$800	\$800
4. 75% of Medicare Reimbursement Level	\$600	\$600
5. Calendar Year Deductible	\$200	\$500
6. Benefit Level	\$400	\$100
Line 4 minus Line 5		
7. Applied to Out of Pocket	\$200**	\$800*

*Represents Usual & Customary amount minus the Benefit amount.

**N/A in state, Out of State – Non Low Income Benefit Levels apply

Out-Of-Pocket Maximum

	<u>Individual</u>	<u>Family</u>
Applies to Non Low Income plan and Low Income outside of CT	\$2,500	\$5,000

Low-Income

1. Calendar Year Deductible
2. Out of Connecticut medical expenses above the benefit amount paid by the Special Health Care Plan, and less than the Usual & Customary Charge*, will be applied to the Out-Of –Pocket Maximum.

Non-Low Income

1. Calendar Year Deductible
2. Amount Paid by the covered person that is the difference between the Usual & Customary Charge*, and the benefit amount paid by the Special Health Care Plan.

*The Usual & Customary Charge is the usual charge made for services or supplies for individuals with similar medical conditions, living in the same area.

Non-Notification Cash Deductible

You must notify the Utilization Review Unit (Patient Advocate) each time hospitalization, certain surgical procedures or treatment plans are proposed. If the Utilization Review Unit is not notified, the lesser of \$200 or 50% of the scheduled benefit in the policy must be paid. This deductible is not included in the calculation of the Out-Of-Pocket maximum.

Covered Medical Expenses

- Mental Health Benefits- Policy covers up to 60 days of inpatient care, and up to \$2000 for outpatient care, per calendar year.
- Alcohol/Substance Abuse Treatment – Policy covers up to 45 days in a treatment center and up to \$1000 for outpatient care, per calendar year.
- Skilled Nursing Facility Care – Policy covers up to 120 days per calendar year in a skilled nursing facility.
- Hospital Services – Semi- private room rate.
- Physician Services– Annual Physicals and Routine Gynecological Exams
- Preventative Pediatric Care – For children under age 7
 - Every two months from birth to 6 months
 - Every three months from 9 to 18 months
 - Annually for 2 to 6 years
- Physical, Speech, Occupational and Respiratory Therapy
- Home Health Care Services - 80 visits per calendar year
- Hospice Care – ward or semi-private room. No day limits.
- Birth Center Care –
 - Room & Board Charges.
 - Anesthetics and the charges for administering them.
- X-ray, Radium and Radioactive Isotope Therapy
- X-ray, Lab and Pathology Tests
- Outpatient Chemotherapy
- Anesthesia and Oxygen
- Ambulance Services
- Medical/Surgical Equipment
- Screening Mammography
 - One Mammogram every two years for women ages 35 to 39.
 - One mammogram every two years, or more frequently, if recommended by a Physician for women ages 40 to 49.
 - One annual mammogram for women ages 50 or over
- Diagnostic Tests

Expenses Not Covered

- Prescription Drugs – **Except** when administered in an inpatient setting.
- Private Duty Nursing
- Medical Treatment Before Coverage Begins, or while the person is not covered
- Unnecessary Medical Care
- Cosmetic Treatments
- Services provided by individuals not specifically covered
- Work Related Injuries or Diseases
- Injuries or Sickness Caused By War or Armed International Conflict
- Services The Covered Person is not required to pay
- Benefits covered by any government entity, state no-fault laws, or school
- Transportation (except an ambulance to the nearest hospital)
- Custodial care or care designed to assist in the activities or Daily Living.
- Eyeglasses, Contact Lenses, Hearing Aids, or the fitting of these, unless required by an accidental injury.
- Treatment of Teeth or Gums, unless required by an accidental injury which occurs while covered and certain surgical procedures.
- Services performed by a relative, or spouse's relative, or any caregiver that lives in the covered individual's home.
- Immunizations and medical examinations not required to treat a covered injury or disease and routine Well Baby Care.
- Dietary Services if not medically necessary
- Sex change operations, Artificial Insemination, In-Vitro Fertilization or Embryo Transfer
- Voluntary Sterilization or the Reversal of Voluntary Infertility.
- Acupuncture, Except as Anesthesia during a Covered Medical Procedure by a Physician.
- Marriage, Family and Child counseling except as Medically Necessary.
- Speech Therapy, except for treatment to restore Speech Lost as a result of injury or disease.
- Blood and Blood products
- Experimental or Investigational Services
- Routine foot care, except as Medically Necessary
- Services of Volunteers or persons who do not normally charge for their services.
- Private room accommodations in excess of the Semi-private room rate
- Services of Pastoral Counselors performing normal duties of a Pastor or Minister
- Care in Institutions in excess of the rate approved by The Commission on Hospital and Health Care.
- Expenses beyond the Scope of License of the Provider or Institution

Renewal and Termination

The Plan may be renewed except for one of the following reasons:

- The Covered person reaches age 65 and is eligible for Medicare
- The Association no longer issues policies based on Connecticut Statute, Chapter 700c, Section 38a-556 due to a change in state or federal law.
- Coverage for any person covered under the plan will terminate at the end of the term in which any of the following occur:
 1. The spouse of the Insured will terminate at the end of the term that divorce, annulment or legal separation is granted.
 2. A child will terminate at the end of the term in which the child is married, reaches the limiting age, or is no longer dependent on the Insured for support.
 3. A written request is received from the Insured.
 4. Non payment of premium.

Please send completed application and applicable premium to:

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

FOR MORE INFORMATION ABOUT PLANS AVAILABLE THROUGH HRA CONTACT OUR OFFICE
AT 1-800-842-0004. HOURS OF OPERATION ARE MONDAY THROUGH FRIDAY 9:00AM TO
4:00PM.

2009 HRA PLAN RATES

Monthly Premium Rates per Individual
Special Low Income – Conversion Plan

Attained Age	Male	Female	One Child	Children
<30	\$207.35	\$403.54	\$201.92	\$405.08
30-39	\$263.38	\$420.95		
40-49	\$364.62	\$453.90		
50-59	\$611.72	\$587.58		
60-64	\$900.61	\$762.92		

2009 HRA PLAN RATES

Monthly Premium Rates per Individual
Special Non-Low Income – Conversion Plan

Attained Age	Male	Female	One Child	Children
<30	\$592.07	\$1,152.26	\$576.58	\$1,156.65
30-39	\$752.06	\$1,201.98		
40-49	\$1,041.14	\$1,296.06		
50-59	\$1,746.69	\$1,677.78		
60-64	\$2,571.61	\$2,178.44		

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 your age and gender.
2. Get rates for other family members to be covered based on their ages and genders.
3. Add together all the rates for your family members. This your total monthly cost of coverage

Low Income Guidelines

Family Members	1	2	3	4
Adjusted Gross Income	\$31,200	\$42,000	\$52,800	\$63,600
(On last Federal Tax Return)				
Family Members	5	6	7	8
Adjusted Gross Income	\$74,400	\$85,200	\$96,000	\$106,800
(On last Federal Tax Return)				

Add \$3,600 to the base for each additional family member

** If you did not file a Federal Tax Return, please call the Treasury Dept. at 1-800-829-1040 and request letter # 1722(ICP) or Form 4506T to verify income

Special Health Care Conversion Application

Health Reinsurance Association (CT)

Section I

Income Status Based Upon the Adjusted Gross Income on Prior Year's Federal Tax Return			
<input type="checkbox"/> Low Income (Prior year's Federal Tax Return must accompany application)		<input type="checkbox"/> Non Low Income	
Please enter the Adjusted Gross Income amount from last year's tax return \$ _____ . If you did not file a Federal Tax Return, please call the Treasury Department at 1-800-829-1040 and request form #1722(ICP) or Form 4506T to verify income and attach it to your application.			
Applicant's Name		Social Security Number	Date of Birth
Home Address (Street)		Town	State & Zip Code
Billing Address (if different from Home Address)		Town	State & Zip Code
Applicant's Gender <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Connecticut Resident <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	CT Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	CT Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	CT Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	CT Resident <input type="checkbox"/> Yes <input type="checkbox"/> No

Section II Please answer the following questions.

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

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
				<input type="checkbox"/> Group <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual
				<input type="checkbox"/> Group <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual
				<input type="checkbox"/> Group <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> 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, applicable monthly premium, verification of coverage, and Tax Return 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 four 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.

4. VERIFICATION OF INCOME – to qualify for the Low Income rate applicant must provide one of the following forms of documentation.

- ❖ Copy of your Federal Tax Return – If you have filed on a standard 1040 form we only need the 1st page of the tax return.
- ❖ 1722 (ICP) Letter or Form 4506 T from the Treasury Dept. – To obtain this form call the IRS at 1-800-829-1040.
- ❖ Letter from a CPA (Certified Public Accountant) to verify that you were not required to file a tax return. - The letter must include the accountant's name, address, phone number and license number.

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