

# HMO PORTABILITY PLAN

For Connecticut Residents



Health Reinsurance Association  
100 Great Meadow Road, Suite 704  
Wethersfield, CT 06109  
1-800-842-0004  
[www.hract.org](http://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.

Effective January 1, 1998, HRA offers Portability Plan options based on the Health Insurance Portability and Accountability Act (HIPAA) to qualified individuals.

# **TABLE OF CONTENTS**

**Who Is Eligible.....Page 1**

**Definitions.....Page 1**

Eligible Dependents

Pre-existing Conditions

Effective Date of Policy

**How to Choose a Plan.....Page 2**

**How a HMO Plan Works.....Page 2**

**Benefit Description.....Pages 3-5**

**Managed Care Terms.....Page 6**

**Health Reinsurance Association Contact Information....Page 6**

**HMO Portability Plan Rate Sheet.....Page 7**

**HMO Portability Plan Application.....Page 8-9**

## **Who is Eligible?**

- All Connecticut residents under the age of 65. Connecticut residents who are over the age of 65 and are not covered under Medicare Part A & Part B
- You have had continuous creditable coverage for at least 18 months.
- Last day of coverage is at least one day of group coverage.
- You are not eligible for or have exhausted other group health insurance coverage including COBRA, if it was offered to you.
- Your application and premium are 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 due to involuntary loss of coverage. The HRA plan will begin coverage the 1<sup>st</sup> 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.

## **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. Under the Health Reinsurance Association Portability plans, pregnancy is not considered a pre-existing condition.

**Portability Plans:** If you are eligible for the Portability Plan, there is no waiting period for pre-existing medical conditions.

If you don't qualify for the Portability Plan, you may still be eligible for a Conversion or Individual policy through HRA. The Conversion policies are guarantee issue and would still cover pre-existing conditions immediately. The Individual policies are guarantee issue with a 12-month waiting period for pre-existing medical conditions. Please contact HRA for more information.

**Effective Date:** The effective date will be the 1<sup>st</sup> 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.**

## **Plan Options and How to Choose**

**Options:** If you are eligible for a portability 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 portability 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 or PPO Portability 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](http://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 per Day to a maximum of \$1,000 per Inpatient Hospital Admission
Outpatient	\$25 Co-payment
Emergency Room	\$75 Co-payment

### **Skilled Nursing Facility**

\$250 per Day to a maximum of \$1,000 per Inpatient Skilled Nursing Facility Admission.  
120 days maximum. No Co-pay if confinement immediately follows a hospitalization  
No deductible 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

### **Prostate Screening (PSA)**

Laboratory – No Cost (Plan pays 100%)  
Diagnostic Tests - \$25 Co-Payment

**Colorectal Cancer Screening** - Annual fecal occult blood test and a colonoscopy, flexible sigmoidoscopy, or radiological imaging.

### **Eye Exams**

\$25 Co-payment per visit

### **Ambulance**

No cost if medically necessary. Plan will not pay more than the maximum allowable rate established by the Department of Public Health.

### **Pediatric Well Care**

No cost up to age 6.

Including immunizations <b><u>Other Routine Exams</u></b>	\$25 Co-payment per visit
<b><u>Immunizations</u></b>	No Cost (Plan pays 100%)
<b><u>Lyme disease treatment</u></b>	No less than 30 days intravenous antibiotic therapy and/or 60 oral antibiotic therapy and further treatment if recommended by a board certified rheumatologist, infectious disease specialist or neurologist.
<b><u>Routine Mammograms</u></b>	One Baseline Mammogram for women between the ages of 35-39. One annual mammogram for women age 40 or over.
<b><u>Routine Obstetric and Gynecological Exams</u></b>	\$25 Co-payment
<b><u>Maternity including Pre/Postnatal Care</u></b>	No cost for outpatient visits
<b><u>Hospice Care</u></b>	No cost if you are confined (Plan pays 100%)
<b><u>Home Health Care</u></b>	\$50 deductible
<b><u>Alcohol/Substance Abuse</u></b>	<u>Inpatient</u> : \$250 per Day to a maximum of \$1,000 per Inpatient Admission <u>Outpatient</u> : \$25 Co-payment per visit
<b><u>Mental Health</u></b>	<u>Inpatient</u> : \$250 per Day to a maximum of \$1,000 per Inpatient Admission <u>Outpatient</u> : \$25 Co-payment
<b><u>Partial Hospitalization</u></b>	\$25 Co-payment per session
<b><u>Prescriptions</u></b>	Three Tier Co-payment \$10/\$25/\$40. Must be FDA approved.
<b><u>Diabetic Supplies</u></b>	Plan pays 100% Prescription Drugs Equipment: Example: Glucometer Supplies: Testing Strips, Syringes, Hypodermic Needles, etc.
<b><u>Diabetes Self-Management Training</u></b>	\$25 Co-payment
<b><u>Protein Modified Foods</u></b>	For the therapeutic treatment of inherited metabolic diseases and are administered by a physician.
<b><u>Specialized Formula</u></b>	For children up to age 8 when for treatment disease or condition and when under the direction of a physician.
<b><u>Durable Medical</u></b>	\$400 Co-payment per item
<b><u>Hearing Aids</u></b>	\$1,000 benefit within a 24 month period for children age 12 or younger.

**Ostomy appliances and Supplies** \$1,000 annual limit

**Prostheses** \$400 Co-payment per item. No cost for internal prostheses. (Plan pays 100%)

**Pain Management** \$25 Co-payment

**Cancer Clinical Trials** \$25 Co-payment for any outpatient or physician services, \$10/\$25/\$40 Co-payment for prescriptions (must be approved by the Food and Drug Administration.)  
\$250 per Day to a maximum of \$1,000 per Inpatient Admission

**Infertility Treatment** Medically necessary expenses of the diagnosis and treatment of infertility, including in-vitro fertilization procedures.

**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 Portability Plan

<b>Attained Age</b>	<b>Male</b>	<b>Female</b>	<b>Child(ren)</b>
<30	\$424.01	\$825.19	\$620.29
30-34	\$512.94	\$867.44	
35-39	\$564.23	\$854.30	
40-44	\$677.04	\$894.34	
45-49	\$836.82	\$973.79	
50-54	\$1,102.73	\$1,118.68	
55-59	\$1,443.16	\$1,306.99	
60-64	\$1,841.65	\$1,560.08	
65+ Medicare Primary	\$1,270.74	\$1,076.46	

**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 Portability Plan Application Health Reinsurance Association (CT) Health Net

Applicant's Name		Social Security Number	Date of Birth	Marital Status
Home Address (Street)		Town	State & Zip Code	Connecticut Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
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.

1. Have you had at least 18 months of continuous coverage with at least the last day being group coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you exhausted all group insurance options including COBRA, if it was offered to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please attach verification of coverage.</b>
3. 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
4. If you answered "No" to #3, 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
5. Are you eligible for coverage under a group health plan, Medicaid or Medicare Part A and/or Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No

**If you have answered "No" to questions 1, 2 and/or 4, you do not qualify for our Portability plans. If you have answered "Yes" to question 5, you are not eligible for our Portability plans. Please contact our office for our Conversion and/or Individual plan options.**

Over

**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.**

Applicant's Signature	Date
-----------------------	------

**If application is being signed by an Executor or Power of Attorney, please provide appropriate documentation**

**Please Note: Policy will be made effective the first day of the month following receipt of the completed application and the first monthly premium.**

Effective Date of Coverage	By	Date
----------------------------	----	------

**Endorsed By Health Reinsurance Association (Connecticut)**

**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 and Certificate 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, or
  2. COBRA Administrator

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