

PPO INDIVIDUAL 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.

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

Individual Plans have a 12 month waiting period for any pre-existing medical condition.

Effective Date

Individual Policies will become effective on the first of the month after receipt of a completed application and the premium for the first term.

Health Benefits

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

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 Health Care

A listing of providers can be found at www.unitedhealthcare.com

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

	<u>In-Network</u>	<u>Out of Network</u>
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
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Occupation/Speech Therapy

80% after deductible		60% after deductible
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<u>X-ray and Lab Exams</u>	80% after deductible	60% after deductible
<u>X-ray Therapy</u>	80% after deductible	60% after deductible
<u>Eye Exams</u>	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)
<u>Ambulance</u>	80% after deductible	60% after deductible
<u>Pediatric Well Care</u> Including immunizations	100% No deductible required	100% No deductible required
<u>Other Routine Exams</u>	80% after deductible	60% after deductible
<u>Immunizations</u>	80% after deductible	60% after deductible
<u>Maternity including</u> Pre/Postnatal Care	80% after deductible (Deductible waived for prenatal care)	60% after deductible (Deductible waived for prenatal care)
<u>Hospice Care</u>	80% after deductible	60% after deductible
<u>Home Health Care</u>	80% after deductible	60% after deductible
<u>Alcohol/Substance Abuse</u>	80% after deductible <u>Inpatient:</u> 45 days maximum per calendar year <u>Outpatient:</u> \$1000 per calendar year maximum	60% after deductible
<u>Mental Health</u>	80% after deductible <u>Inpatient:</u> 60 days maximum per calendar year <u>Outpatient:</u> \$2000 per calendar year maximum	60% after deductible
<u>Partial Hospitalization</u>	80% after deductible 120 sessions maximum per calendar year. (2 sessions count as 1 inpatient day)	60% after deductible
<u>Outpatient Prescriptions</u>	\$250 Deductible then 3 Tier co-pay of \$10/\$25/\$40	
<u>Durable Medical</u>	80% after deductible	60% after deductible
<u>Prostheses</u>	80% after deductible	60% after deductible
<u>Non-notification Penalty</u>	The amount you pay if you do not receive pre-approval for certain services. See Contract.	

Managed Care Terms

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.

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 Individual 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 Individual Application
Health Reinsurance Association (CT)
United Health Care**

Please Note: Any policy issued on this application will become effect the 1st of the month following receipt of application

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
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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

1. Are you eligible for coverage under a group health plan, Medicaid, Medicare Part A and/or Part B? If yes, please complete the table below.	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Do you have any other health insurance coverage? If yes, please complete the table below.	<input type="checkbox"/> YES <input type="checkbox"/> NO

Table of Other Coverage

Name of Individual Covered	Name of Carrier	Policy Number	Effective Date	Type of Coverage
				<input type="checkbox"/> Medicare-Part A <input type="checkbox"/> Medicare-Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Other
				<input type="checkbox"/> Medicare-Part A <input type="checkbox"/> Medicare-Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Other
				<input type="checkbox"/> Medicare-Part A <input type="checkbox"/> Medicare-Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Other

Over

3. 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
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If application is being signed by an Executor or Power of Attorney, please provide appropriate documentation

Effective Date of Coverage	By	Date
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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 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 two 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”

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