HRA
Health Reinsurance Association

Special Health Care Plan
Low Income Portability Plan

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for: Member & Family** **Plan Type: IND**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling the Health Reinsurance Association (HRA) at 1-800-842-0004.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** Individual / **$1,000** Family Per calendar year. Does not apply to copays and services listed below as "No Charge".	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No. There are no other deductibles.	Please see the Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Services rendered outside of Connecticut have an out-of-pocket limit of $2,500. Once the out-of-pocket limit is met, the plan will pay 100% of reasonable and customary charges. Providers may bill you for amounts above reasonable and customary charges.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain for services and services that are not covered are not included in out-of-pocket limit.	Services that are not covered are not included in out-of-pocket limit. Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No. There is a lifetime maximum of $1,500,000.	This plan will pay for covered services only up to this limit during each person's lifetime, even if your own need is greater.
Does this plan use a network of providers?	No, the plan doesn't use a network. You may use any provider. Providers in Connecticut must accept the plan payment as payment in full. Providers are not allowed to bill you for any difference. Providers outside of Connecticut are allowed to bill you for any difference above what the plan pays.	The plan works differently in Connecticut and outside of Connecticut. Please be aware that providers outside of Connecticut may bill you for amounts above what the plan pays.
Do I need a referral to see a	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

specialist?		
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.

Co-insurance (co-ins) is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. The amount the plan pays for covered services is based on the Medicare allowed amount. The plan pays 75% of the Medicare allowed amount.

Common Medical Event	Services You May Need	Your cost if you use a Connecticut Provider	Your cost if you use a Outside of Connecticut Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
	Specialist visit	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
	Other practitioner office visit	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Limited to 20 visits of Manipulative (Chiropractic) services per calendar year.
	Preventive care / screening / immunization	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
	Imaging (CT / PET scans, MRIs)	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None

If you need drugs to treat your illness or condition*	Tier 1 – Your Lowest-Cost Option	Retail: Not Covered Mail-Order: Not Covered	Not Covered	*Limited coverage for outpatient prescription drugs as specified in the health care reform law and the Connecticut Insurance Law.
	Tier 2 – Your Midrange-Cost Option	Retail: Not Covered Mail-Order: Not Covered	Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: Not Covered Mail-Order: Not Covered	Not Covered	
	Tier 4 – Additional High-Cost Option	Retail: Not Covered Mail-Order: Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
	Physician / surgeon fees	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
If you need immediate medical attention	Emergency room services	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
	Emergency medical transportation	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	$500.00 maximum benefit per occurrence.
	Urgent care	0% co-ins, after ded.	25% co-ins after ded.	None

			plus any provider charges above the amount the plan pays.	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Pre-Authorization is required. Penalty for failure to authorize a Covered Service: The combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of 50% of the scheduled benefit or $200.
	Physician / surgeon fees	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Mental / Behavioral health treatment is treated as any other illness.
	Mental / Behavioral health inpatient services	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Mental / Behavioral health treatment is treated as any other illness. Pre-Authorization is required. Penalty for failure to authorize a Covered Service: The combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of 50% of the scheduled benefit or $200.
	Substance use disorder outpatient services	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Substance use disorder treatment is treated as any other illness.

	Substance use disorder inpatient services	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Substance use disorder treatment is treated as any other illness. Pre-authorization is required. Penalty for failure to authorize a Covered Service: The combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of 50% of the scheduled benefit or $200.
If you become pregnant	Prenatal and postnatal care	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
	Delivery and all inpatient services	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
If you have a recovery or other special health needs	Home health care	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Limited to 80 visits per calendar year. Pre-Authorization is required. Penalty for failure to authorize a Covered Service: The combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of 50% of the scheduled benefit or $200.
	Rehabilitation services	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Any combination of outpatient rehabilitation services is limited to 30 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.

	Skilled nursing care	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Limited to 120 days per calendar year. The limit is combined with IP Rehabilitation Services. Pre-Authorization is required. Penalty for failure to authorize a Covered Service: The combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of 50% of the scheduled benefit or $200.
	Durable medical equipment	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
	Hospice service	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	None
If your child needs dental or eye care	Eye exam	0% co-ins, after ded.	25% co-ins after ded. plus any provider charges above the amount the plan pays.	Limited to 1 exam every 2 years. Eye refractions are not covered.
	Glasses	Not covered.	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult/Child - Limited coverage for dental as specified in Connecticut Insurance Law.)	• Glasses • Habilitation Services • Long-term care	• Non-emergency care when traveling outside the U.S. • Routine foot care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture- may be covered with limitations • Hearing aids- may be covered with limitations	• Infertility Treatment- may be covered with limitations	• Private-duty nursing- may be covered with limitations • Routine eye care (Adult) - may be covered with limitations

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.
若需要中文协助，请拨打您会员卡上的电话号码
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page*. ----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7,540
- ☐ **Plan Pays** $6,840
- ☐ **Patient Pays** $700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Out Patient Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$0
Co-insurance	$0
Limits or exclusions (Out Patient Prescriptions)	$200
Total	**$700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $5,400
- ☐ **Plan Pays** $3,900
- ☐ **Patient Pays** $1,500

Sample care costs:

Out Patient Prescriptions (Diabetes Related)	$1,900
Out Patient Prescriptions (Non-Diabetes Related)	$1,000
Medical Equipment and Supplies (Diabetes Related)	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Co-pays	$0
Co-insurance	$0
Limits or exclusions (Non-Diabetes Related Out Patient Prescriptions)	$1,000
Total	**$1,500**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call HRA at 1-800-842-0004. If you aren't clear about any of the terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary**.
It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by HRA for complete terms of this plan.