

INSTRUCTIONS - You must complete this form CO-1 "Charter Oak Health Plan Quick Start Application" to begin the application process. Once you complete and sign this form, mail it to: **Charter Oak Health Plan, P.O. Box 280747, East Hartford, CT 06128.**

Earned income - Tell us how much money anyone in your household receives from employment each month. We need to know the amount before taxes or other items like deferred savings are taken out. If you are self-employed, please tell us your income after business expenses are deducted.

Unearned income - Tell us how much money anyone in your household receives that is not from employment. Examples of this would be income from Unemployment Compensation, Social Security, alimony or retirement benefits.

Daycare expenses - Please tell us if you pay daycare expenses for a child or disabled adult so you can work or run your business. You may qualify for a deduction from your reported monthly income.

Household members - Enter the names of everyone who lives in your home, their dates of birth and relation to you, even if they do not want to enroll in Charter Oak Health Plan. Income and family size help determine your premium and deductible amounts. **Please attach a separate sheet of paper if you need more space.**

FOR ALL APPLICANTS

I understand and agree to the following:

1. If I have been insured in the last 6 months, I do not qualify for Charter Oak Health Plan unless I meet one of the exceptions to this requirement. DSS or its agent will provide me with the criteria and process for requesting an exception.
2. Income and family size determine the premium and deductible amounts I will be required to pay. DSS or its agent will use the information on this form to provide me with an estimate of the monthly premium and deductible. While I will receive this information prior to enrolling in a health plan, the additional information I provide on the follow-up application will be used to determine the actual monthly premium and deductible amounts I will be required to pay. I will be notified before enrollment into a health plan if the review of the follow-up application results in a change of premium and deductible amounts.
3. DSS or its agent will use the information provided on this application and any information on the follow-up application to determine eligibility for other DSS health care programs including, but not limited to, Medicaid or HUSKY. If I qualify for another publicly funded health insurance plan, I will not qualify for Charter Oak Health Plan.
4. I may ask for a review of a decision if I disagree with an action taken by the Charter Oak Health Plan.
5. All information given on this form is subject to verification by federal, state and local officials. I agree to cooperate with these officials by providing authorizations, documents and other information to prove what I have said. I authorize DSS to verify any information given on this form.
6. All information given on this form, including Social Security numbers, is confidential, except as authorized or required by state or federal law, and will be used only to administer medical programs or verify the income stated on this application.
7. The Social Security numbers of all people requesting assistance will be used to verify identity, eligibility and income. Social Security numbers also will be cross-matched against federal, state and local government files by computer. Social Security numbers are required for determining eligibility for Medicaid, based on 42 U.S.C. §§ 1320b-7(a) (1), (b)(2), and are voluntary for the Charter Oak Health Plan. Your social security number will allow DSS or its agent to verify your stated income. If you do not provide Social Security numbers, you may be required to submit wage verification, for example, pay stubs.
8. I will notify DSS or its agent within 10 days of any change in family circumstances, for example, income, other medical insurance, address, or household size.

READ CAREFULLY AND SIGN

I have read this form or have had it read to me in a language that I understand. I swear that the information given on this form is true and complete to the best of my knowledge. If I have knowingly given incorrect information, I understand that there are penalties for false statement as specified in the Connecticut General Statutes sections 53a-157b and 17b-97 and to penalties for larceny as specified in sections 53a-122 and 53a-123. I also may be subject to penalties for perjury under federal law. I authorize DSS to verify any information given on this form.

Applicant's or Representative's Signature _____ Date _____

Witness' signature (if signed with an X) _____ Date _____



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1-877-77CTOAK

Charter Oak Health Plan
 C/O Department of Social Services
 25 Sigourney Street
 Hartford, CT. 06106

Benefit Package

Medical Benefit Features	Coverage
Premium	\$75-\$259*
Deductible	Varies*
Primary Care Office Visit	\$25 co-pay
Specialist Office Visit	\$35 co-pay
Preventive Care Office Visits	100% coverage, no co-pay
Emergency Room Visit	\$100 (waived if emergency)
Prescription Medication	Three-tiered co-pay as low as \$10, \$7,500 annual benefit limit
Durable Medical Equipment	\$4,000, no co-pay
Behavioral Health Services	\$35 co-pay (provided through CT Behavioral Health Partnership)
Outpatient Rehabilitation	\$35 co-pay, 30 visits per year
Maternity Pre- and Post-Natal Care	100% covered
Inpatient Rehabilitation/Skilled Nursing	14 days per year, 80% covered after deductible met
Inpatient Hospital Visits	90% covered after deductible met
Outpatient Surgical	80% covered after deductible met
Lifetime Benefit Maximum	\$1 million
Annual Benefit Maximum	\$100,000

**Based on Income*

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Qualifying for Reduced Premiums

Depending on your income, you may be eligible for a reduced premium and deductible as a Charter Oak member. This chart will give you an indication of the cost. Remember, though, adults of all incomes from age 19 through age 64 can join Charter Oak.

Household Size/Income						Charter Oak Premium	Charter Oak Annual Deductible*
1	2	3	4	5	6		
under \$15,600	under \$21,000	under \$26,400	under \$31,800	under \$37,200	under \$42,600	\$75/mo. Per member	\$150 Ind./ \$300 Family
\$15,600 to \$19,240	\$21,000 to \$25,900	\$26,400 to \$32,600	\$31,800 to \$39,200	\$37,200 to \$45,900	\$42,600 to \$52,500	\$100/mo. Per member	\$200 Ind./ \$350 Family
\$19,241 to \$24,400	\$25,901 to \$32,900	\$32,601 to \$41,400	\$39,201 to \$49,400	\$45,901 to \$58,300	\$52,501 to \$66,700	\$175/mo. Per member	\$400 Ind./ \$600 Family
\$24,401 to \$31,200	\$32,901 to \$42,000	\$41,401 to \$52,800	\$49,801 to \$63,600	\$58,301 to \$74,400	\$66,701 to \$85,200	\$200/mo. Per member	\$750 Ind./ \$1400 Family
over \$31,200	over \$42,000	over \$52,800	over \$63,600	over \$74,400	over \$85,200	\$259 max/ mo. Per member	\$900 Ind./ \$1750 Family

**Deductible applies to inpatient hospital, outpatient surgical and inpatient rehabilitation/skilled nursing.*

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