



# Medical Benefit Summary

Administered by UnitedHealthcare

## IN NETWORK

## CT Partnership Plan w/Health Enhancement Program

Deductible	Not applicable*
Coinsurance	Not applicable
Max Out-of-Pocket Limit	Not applicable
Medical Office Visit	\$15 Co-pay
Specialist Office Visit	\$15 Co-pay
Vision Exams (one per calendar year)	\$15 Co-pay
Inpatient Hospital	\$0 Co-pay
Outpatient Surgical	\$0 Co-pay
Emergency Room	\$35 Co-pay (waived if admitted)
Urgent Care	\$15 Co-pay
Walk In	\$15 Co-pay
Lab/ X-Ray	\$0 Co-pay
High Cost Radiological & Diagnostic Tests	\$0 Co-pay
MRI, MRA, CAT, CTA, PET and SPECT scans (Prior authorization required)	\$0 Co-pay

## PREVENTIVE SERVICES

Primary Care (Adult and Child Wellness Exams)	\$0 Co-pay
Gynecologist Wellness	\$0 Co-pay
Mammogram	\$0 Co-pay
Lifetime Maximum	Unlimited

## PRESCRIPTION COVERAGE

	Maintenance Drugs	Non-Maintenance Drugs	HEP Chronic Condition Drugs
Generic	\$5.00	\$5.00	\$0.00
Preferred/Listed Brand Name	\$10.00	\$20.00	\$5.00
Non-Preferred/Non-Listed Brand Name	\$25.00	\$35.00	\$12.50
Annual Maximum		Unlimited	

## OUT OF NETWORK

Annual Deductible	\$300 individual/\$900 family
Coinsurance	20% of allowable charges + 100% of billed charges in excess of allowable charges
Max Out-of-Pocket Limit	\$2,300 individual/\$4,900 family
Lifetime Maximum	Unlimited

\* Waived for enrollees in Health Enhancement Program. Non-HEP Enrollees are subject to \$350 Ind./\$1,400 Family in-network deductible.

Visit [www.OXHP.com/stateofct](http://www.OXHP.com/stateofct) to search the list of network providers.



# Dental Benefit Summary

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	OPTION #1	OPTION #2
	Not Enrolled in Health Enhancement Program	Enrolled in Health Enhancement Program
	IN NETWORK	IN NETWORK
Annual Deductible	\$25 Individual/\$75 Family	\$25 Individual/\$75 Family
Annual Maximum	\$1,000*	\$1,000*
Deductible waived		
Preventive	Yes	Yes
Basic	No	No
Major	No	No
<b>PREVENTIVE</b>		
X-Ray	80%	100%
Cleanings	80%	100%
Oral Exam	80%	100%
Fluoride	80%	100%
<b>BASIC</b>		
Fillings	80%	80%
Endodontics	80%	80%
Periodontics	80%*	80%*
Simple Extractions	80%	80%
<b>MAJOR</b>		
Crown	50%	50%
Inlays	50%	50%
Onlays	50%	50%
Dentures (Repair Only)	50%	50%
Bridges (Repair Only)	50%	50%
Space Maintainers	50%	50%
Oral Surgery	50%	50%
<b>ORTHODONTIA (optional)</b>		
Braces (Child Only)	50%	50%
Lifetime Orthodontia Max	\$1,500	\$1,500

\* (Up to \$500 per person for Periodontics)