



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 UCR 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 to search the list of network providers.



Dental Benefit Summary

Administered by UnitedHealthcare

| | Unlimited Maximum Plan | \$1,500 Annual Maximum Plan | \$1,000 Annual Maximum Plan | \$750 Annual Maximum Plan |
|--|---------------------------|-----------------------------------|-----------------------------------|---------------------------------|
| | IN/OUT NETWORK | IN/OUT NETWORK | IN/OUT NETWORK | IN/OUT NETWORK |
| Annual Deductible | \$0 | \$0 | \$25 Individual/\$75 Family | \$0 |
| Annual Maximum | None | \$1,500 | \$1,000 | \$750 |
| Lifetime Orthodontia Max | N/A | \$1,500 | \$1,500 | N/A |
| Deductible waived | | | | |
| Preventive | Yes | Yes | Yes | Yes |
| Basic | No | N/A | No | N/A |
| Major | No | N/A | No | N/A |
| PREVENTIVE | | | | |
| X-Ray | 100% | 100% | 100% | 100% |
| Cleanings | 100% | 100% | 100% | 100% |
| Oral Exam | 100% | 100% | 100% | 100% |
| Fluoride | 80% | 100% | 80% | 100% |
| BASIC | | | | |
| Fillings | 80% | 80% | 80% | 0% |
| Endodontics | 80% | 80% | 80% | 0% |
| Periodontics | 80%/50%* | 80% | 80%/50%* | 0% |
| Dentures (Repair Only) | 80% | 80% | 80% | 0% |
| Bridges (Repair Only) | 80% | 80% | 80% | 0% |
| Simple Extractions | 80% | 80% | 80% | 100% |
| MAJOR | | | | |
| Crown | 67% | 67% | 50% | 0% |
| Inlays | 67% | 67% | 50% | 0% |
| Onlays | 67% | 67% | 50% | 0% |
| Dentures and Removeable Prosthetics | 0% | 67% | 0% | 0% |
| Fixed Partial Dentures (Bridges) | 0% | 67% | 0% | 0% |
| Space Maintainers | 67% | 100% | 50% | 100% |
| Oral Surgery | 67% | 67% | 50% | 0% |
| ORTHODONTIA | | | | |
| Braces | N/A | 50% (Child Only) | 50% (Adult and Child) | N/A |

* 80% for periodontal cleanings, 50% for other periodontics.