State of CT Partnership Plan
Oxford POS / CVS Caremark Pharmacy

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2016 – 06/30/2017
Coverage for: Individual/Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at http://www.osc.ct.gov/ctpartner/docs/PartMedlPlanDoceff01012016updt9192016.pdf

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$0.** Out-of-network: **$300** Individual / **$900** Family.	You must pay all the costs up to the **deductible** amount before this plan begins to pay. Under the plan document the **deductible** starts July 1st.
Are there other deductibles?	Yes. Upfront deductible for in-network services for those not enrolled in HEP: **$350** Individual / **$350** each family member (**$1,400** maximum).	You must pay all of the costs for in-network services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. Medical: In-network: **$2000** Individual / **$4,000** Family. Out-of-Network: **$2000** Individual/**$4000** Family. Pharmacy: **$4600** Individual/**$9200** Family.	The **out-of-pocket limit** is the most you could pay during the plan year (July 1-June 30) for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Premiums, balance billing, out-of-network cost sharing, charges for non-covered services	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.	The chart on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes.	You will pay less if you use an in-network doctor or other health care **provider**. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay in an out-of-network hospital is $1,000, your **coinsurance** payment of 20% would be $200. This amount may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event				
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com Phone: (800) 318-2572 TDD: (800)238-0756 Benefits provided by CVS/Caremark.	30 day or less supply	$5 copay/Generic /$20 Preferred Brand $35 Non-Preferred Brand $$0 copay/(diabetes medications)	20% Coinsurance when you use a Non-Network pharmacy	Penalty may apply if brand name drug is requested when a generic is available
	Maintenance Drug (90 day supply)	$5 copay/Generic; $10 Preferred Brand; $25 Non-Preferred Brand (For certain chronic condition related maintenance medications for HEP enrolled participants) $0 copay/Generic; $5 copay/Preferred Brand; $12.50 copay/Non-Preferred Brand $0 copay (diabetes medications)	20% Coinsurance when you use a Non-Network pharmacy	90-day supply of maintenance medications available only from mail order or Maintenance Drug Network Penalty may apply if brand name drug is requested when a generic is available
	Specialty drugs	Copay of $5/$20/$35 per prescription based on drug tier (see tiers above) when purchased at retail or designated specialty pharmacy	20% Coinsurance when you use a Non-Network pharmacy	Covers up to a 30-day supply

If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay/visit	20% Coinsurance	————————none————————
	Specialist visit	$15 Copay/visit	20% Coinsurance	50% Coinsurance for eye exam by Out-of-network provider
	Other practitioner office visit	No charge	20% Coinsurance	Chiropractic care out-of-network limited to 30 outpatient days per condition per calendar year.
	Preventive care/screening/ immunization	No charge	20% Coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% Coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	No charge	20% Coinsurance	Prior authorization required; penalty of 20% up to $500 per episode if non-network provider fails to obtain prior authorization
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% Coinsurance	Prior authorization required; penalty of 20% up to $500 per episode if non-network provider fails to obtain prior authorization
	Physician/surgeon fees	No charge	20% Coinsurance	Prior authorization required; penalty of 20% up to $500 per episode if non-network provider fails to obtain prior authorization

If you need immediate medical attention	Emergency room services	$35 Copay/visit	$35 copay/visit	——————none——————
	Emergency medical transportation	No charge	Covered	——————none——————
	Urgent care	$15 Copay/visit	20% Coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% Coinsurance	Prior authorization required; penalty of 20% up to $500 per episode if non-network provider fails to obtain prior authorization
	Physician/surgeon fee	No charge	20% Coinsurance	Prior authorization required; penalty of 20% up to $500 per episode if non-network provider fails to obtain prior authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 Copay/visit	20% Coinsurance	Prior authorization required after 20 visits
	Mental/Behavioral health inpatient services	No charge	20% Coinsurance	Prior authorization required; penalty of 20% up to $500 per episode if non-network provider fails to obtain prior authorization
	Substance use disorder outpatient services	$15 Copay/visit	20% Coinsurance	Prior authorization required after 20 visits
	Substance use disorder inpatient services	No charge	20% Coinsurance	Prior authorization required; penalty of 20% up to $500 per episode if prior authorization is not obtained by non-network provider
If you are pregnant	Prenatal and postnatal care	$15 copay/initial visit	20% Coinsurance	No charge for in-network well child visits and immunizations.
	Delivery and all inpatient services	No charge	20% Coinsurance	——————none——————

If you need help recovering or have other special health needs	Home health care	No charge	20% Coinsurance	Limited to 200 visits per calendar year
	Rehabilitation services	No charge	20% Coinsurance	Out-of-network physical, occupational, and speech therapies limited to 30 visits per condition per calendar year. Prior authorization is required
	Habilitation services	No charge	20% Coinsurance	All habilitation visits count toward your rehabilitation visit limit??
	Skilled nursing care	No charge	20% Coinsurance	Prior authorization required .Out-of-network coverage limited to 60 days per calendar year
	Durable medical equipment	No charge	20% Coinsurance	————————none————————
	Hospice service	No charge	20% coinsurance	Prior authorization required .Out-of-network coverage limited to 60 days per calendar year
If your child needs dental or eye care	Eye exam	$15 copay/visit	50% Coinsurance	Limited to one exam per calendar year
	Glasses	Not covered	Not covered	————————none————————
	Dental check-up	Not covered	Not covered	————————none————————

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.)

- Cosmetic surgery
- Dental care
- Learning Disability Treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Acupuncture (limits apply)
- Allergy testing
- Bariatric Surgery
- Chiropractic care
- Non-urgent coverage outside the United States.
- Infertility treatment (limits apply)
- Smoking Cessation
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-433-5436. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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:

UnitedHealthcare/Oxford
P.O. Box 30432
Salt Lake City, UT 84130-0432
Member Service Associates: 800-385-9055

CVS/Caremark
Prescription Claim Appeals MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

Additionally, a consumer assistance program can help you file your appeal. Contact:

Connecticut Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
(866) 466-4446
www.ct.gov/oha
healthcare.advocate@ct.gov

Does this plan provide Minimum Essential Coverage? Yes.

Does this plan meet Minimum Value Standards? Yes.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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. 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. Your actual care may be different depending on the care you receive, the prices providers charge and other factors. .

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,525
- **Patient pays** $15

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$15
Coinsurance	$0
Limits or exclusions	$0
Total	**$15**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,910
- **Patient pays** $490

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$350
Copays	$60
Coinsurance	$0
Limits or exclusions	$80
Total	**$490**

Questions and answers about the 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 by 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.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.