

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <http://www.osc.ct.gov/ctpartner/docs/PartMedPlanDoc01012016updt9192016.pdf>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <http://www.cciio.cms.gov> or call Oxford at 800-385-9055 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$350/individual; \$1,400/family-waived for HEP members Out-of-Network: \$300/Individual; \$900/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. Primary care and <u>specialist</u> office visits, <u>preventive</u> care, <u>prescription</u> drugs, emergency room care, urgent care, mental health and substance abuse outpatient services, and eye exams are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Medical: \$2,000/individual; \$4,000/family <u>Prescription drugs</u> : \$4,600/individual; \$9,200/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Out-of-network deductible and cost sharing, premiums, balance-billing charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See http://partnershipstateofct.welcometouhc.com/home or call 800-385-9055 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copay and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge. <u>Deductible</u> does not apply.	\$15 <u>copay</u> /visit. Waived if no in-state preferred provider. <u>Deductible</u> does not apply.		None.
	<u>Specialist</u> visit	No charge. <u>Deductible</u> does not apply.		20% <u>coinsurance</u>	
	<u>Preventive</u> care/ <u>screening</u> /immunization	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization required to avoid penalty: lesser of \$500/20% of cost.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.osc.ct.gov/benefit/s/pharmacy.htm	Generic drugs	Preferred generic: Retail: \$5 <u>copay</u> ; Mail order & maintenance drugs: \$5 <u>copay</u> . Non-preferred generic: Retail: \$10 <u>copay</u> ; Mail order & maintenance drugs: \$10 <u>copay</u>		20% <u>coinsurance</u> for non-participating pharmacy	Retail: 30-day supply; Mail order: 90-day supply. <u>Deductible</u> does not apply to <u>prescription drugs</u> . Check details of your Rx coverage at: www.osc.ct.gov/benefits/pharmacy.htm . Maintenance drugs must be filled by mail order or by Maintenance Network pharmacy after first retail fill. Penalty may apply if brand name drug is requested when a generic is available. Some drugs require prior authorization. No charge for FDA-approved generic contraceptives (or brand name contraceptives if generic is medically inappropriate).
	Preferred brand drugs	Retail: \$25 <u>copay</u> ; Mail order & maintenance drugs: \$25 <u>copay</u> .		20% <u>coinsurance</u> for non-participating pharmacy	
	Non-preferred brand drugs	Retail: \$40 <u>copay</u> ; Mail order & maintenance drugs: \$40 <u>copay</u> .		20% <u>coinsurance</u> for non-participating pharmacy	
	<u>Specialty drugs</u>	Same as non-preferred brand drugs		Same as non-preferred brand drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of covered services.
	Physician/surgeon fees	No charge			
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay/visit</u> . <u>Deductible</u> does not apply.		Same as in-network plus excess over allowed amount.	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge		No charge	None.
	<u>Urgent care</u>	\$15 <u>copay/visit</u> . <u>Deductible</u> does not apply.		20% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of covered services. No coverage in excess of cost of a semi-private room unless <u>medically necessary</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	No charge		20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of covered services.
	Outpatient services	\$15 <u>copay</u> /visit. <u>Deductible</u> does not apply.		20% <u>coinsurance</u>	None.
	Inpatient services	No charge		20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of covered services.
If you are pregnant	Office visits	\$15 <u>copay</u> /first visit only. <u>Deductible</u> does not apply.		20% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests & services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge		20% <u>coinsurance</u>	Prior authorization required for stay in excess of 48 hours (96 hours for cesarean delivery) to avoid penalty of lesser of \$500 or 20% of covered services.
	Childbirth/delivery facility services	No charge		20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge		20% <u>coinsurance</u>	Limit: 200 visits/calendar year.
	<u>Rehabilitation services</u>	No charge		20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of covered services. In-network speech therapy limit: 30 visits/calendar year. Limit does not apply to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of oropharynx. Out-of-network physical, occupational, chiropractic, speech & autism therapy limit: 30 visits/condition/calendar year.
	<u>Habilitation services</u>	Not covered.		Not covered.	You must pay 100% of this service, even in-network.
	<u>Skilled nursing care</u>	No charge		20% <u>coinsurance</u>	Out-of-network limit: 60 visits/ year/ person Prior authorization required to avoid penalty of lesser of \$500 or 20% of covered services.
	<u>Durable medical equipment</u>	No charge		20% <u>coinsurance</u>	Prior authorization required for items over \$500 to avoid penalty of lesser of \$500 or 20% of covered services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	<u>Hospice services</u>	No charge		20% <u>coinsurance</u>	Inpatient services: prior authorization required to avoid penalty of lesser of \$500 or 20% of covered services. Out-of-network inpatient services limit: 60 days/person/calendar year. Out-of-network in-home services limit: 200 visits/calendar year
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit. <u>Deductible</u> does not apply.		50% <u>coinsurance</u>	Limit: 1 visit/calendar year performed as part of an exam.
	Children's glasses	Not covered		Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered		Not covered	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Habilitation services
- Non-emergency care when traveling outside the United States (urgent care covered)
- Long-term care
- Routine foot care (except when medically necessary for treatment of diabetes)
- Weight loss programs (except as required by law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit: 20 visits per calendar year)
- Bariatric surgery (prior authorization required)
- Chiropractic care (limit: 30 visits per calendar year for out-of-network services)
- Hearing aids (limit: 1 set per 36 month period; prior authorization required)
- Infertility treatment (prior authorization required)
- Non-emergency care when traveling outside the United States (urgent care only)
- Private-duty nursing (prior authorization required)
- Routine eye care (adult, limit: 1 exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

United Healthcare/Oxford
P.O. Box 30432
Salt Lake City, UT 84130-0432
Member Services Associates: 1-800-385-9055

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 the Connecticut Office of the Health Care Advocate at 1-866-466-4446

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-385-9055.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-385-9055 (UnitedHealthcare/Oxford).

如果需要中文的帮助, 请拨打这个号码 1-800-385-9055 (UnitedHealthcare/Oxford).

Dinek'ehgo shika a't'ohwol ninisingo, kwijigo holne' 1-800-385-9055 (UnitedHealthcare/Oxford).

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$350
- Specialist copayment \$15
- Hospital (facility) \$0
- Other \$0

This **EXAMPLE** event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$350
Copays	\$20
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$430

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$350
- Specialist copayment \$15
- Hospital (facility) \$0
- Other \$0

This **EXAMPLE** event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$70
Copays	\$235
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$365

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$350
- Specialist copayment \$15
- Hospital (facility) \$0
- Other \$0

This **EXAMPLE** event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$350
Copays	\$310
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$660

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please visit <http://osc.ct.gov/benefits.htm>

The plan would be responsible for the other costs of these **EXAMPLE** covered services.