

**State of CT Partnership Plan
Oxford POS / CVS Caremark Pharmacy**

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

Coverage Period: 07/01/2015 – 06/30/2016

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/benefits/docs/PlanDocumentfinal1012015.pdf>.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>In-network: \$0. Out-of-network: \$300 Individual / \$900 Family.</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. Upfront deductible for in-network for members not enrolled in HEP: \$350 Individual / \$350 each family member (\$1,400 maximum).</p>	<p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. Medical: In-network: \$2000 Individual / \$4,000 Family. Out-of-Network: \$2300 Individual/\$4900 Family. Pharmacy: \$4600 Individual/\$9200 Family.</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance-billed charges, out-of-network deductibles (out-of-network out-of-pocket only), and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>

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<p>Does this plan use a network of providers?</p>	<p>Yes. For in-network providers, Oxford: http://stateofct.welcometouhc.com/home</p> <p>Yes. For “maintenance medications” you must use mail order or preferred Maintenance Drug network.</p> <p>See www.caremark.com, click on “Find a Pharmacy” Or call 1-800-318-2572</p>	<p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. 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.</p>
<p>Do I need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without permission from this plan.</p>
<p>Are there services this plan doesn’t cover?</p>	<p>Yes.</p>	<p>Some of the services this plan doesn’t cover are listed on page 6. See your policy or plan document for additional information about excluded services.</p>



- **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 is \$1,000, your **coinsurance** payment of 20% would be \$200. This 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	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
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<p>If you need drugs to treat your illness or condition Benefits provided by CVS/Caremark.</p> <p>More information about prescription drug coverage is available at www.caremark.com Phone: (800) 318-2572 TDD: (800)238-0756</p> <p>condition Benefits provided by CVS/Caremark.</p>	<p>Tier 1 - Generic drugs</p>	<p>\$5 copay/prescription (retail up to 30-day supply) \$5 copay/prescription(up to 90-day supply using mail or preferred pharmacy) \$0 copay/prescription (for certain chronic condition related maintenance medications for HEP enrolled participants with Asthma/COPD, Heart Failure/Heart Disease, Hyperlipidemia, or Hypertension) \$0 copay/(diabetes medications)</p>	<p>20% <u>Coinsurance</u> when you use a Non-Network pharmacy</p>	<p>90-day supply of maintenance medications (mail order or Maintenance Drug Network only)</p> <p>Some drugs are subject to Prior Authorization or quantity limitations.</p>
	<p>Tier 2 - Preferred brand drugs</p>	<p>\$20 copay/prescription (retail up to 30-day supply) \$10 copay/up to 90-day supply using mail or preferred pharmacy)</p> <p>\$5 copay/prescription (For certain chronic condition related maintenance medications for HEP enrolled participants with Asthma/COPD, Heart Failure/Heart Disease, Hyperlipidemia, or Hypertension)</p> <p>\$0 copay (diabetes medications)</p>	<p>20% Coinsurance when you use a Non-Network pharmacy</p>	<p>90-day supply of maintenance (mail order or Maintenance Drug Network only)</p> <p>If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay unless a “medical necessity” exception is obtained by your doctor.</p> <p>Some drugs are subject to Prior Authorization or quantity limitations.</p>
	<p>Tier 3 - Non-preferred brand drugs</p>	<p>\$35 copay/prescription (retail acute)</p> <p>\$25 copay/prescription (mail and preferred pharmacies)</p> <p>\$12.50 copay/prescription (Health Enhancement Program)</p> <p>\$0 copay/prescription (diabetes medications)</p>	<p>20% Coinsurance when you use a Non-Network pharmacy</p>	<p>Covers up to a 30-day supply (retail acute); 90-day supply (mail order or Maintenance Drug Network only)</p> <p>If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay unless a “medical necessity” exception is obtained by your doctor.</p> <p>Prior authorization may apply</p> <p>Some drugs are subject to quantity limitations, and other provisions.</p>

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	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	—————none—————
	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	In-network: \$15 copay/visit for routine eye exam and audiological screening. Out-of-network: 50% coinsurance for eye exam and 20% coinsurance for audiological screening
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 prior authorization is not obtained by non-network provider
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 prior authorization is not obtained by non-network provider

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	Physician/surgeon fees	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 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 prior authorization is not obtained by non-network provider
	Physician/surgeon fee	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 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 prior authorization is not obtained by non-network provider
	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

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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, combined with in and out-of-network
	Rehabilitation services	No charge	20% coinsurance	Out-of-network physical, occupational, and speech therapies limited to 30 outpatient days per condition per calendar year. Prior authorization is required
	Habilitation services	No charge	20% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit
	Skilled nursing care	No charge	20% coinsurance	Prior authorization required; penalty of 20% up to \$500 per episode if prior authorization is not obtained by out-of-network provider. Out-of-network limited to 60 days per calendar year
	Durable medical equipment	No charge	20% coinsurance	—————none—————
	Hospice service	No charge	20% coinsurance	Prior authorization required; penalty of 20% up to \$500 per episode if prior authorization is not obtained by out-of-network provider. Out-of-network limited to 60 days
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—————

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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 | • Learning Disability Treatment | • Routine foot care |
| • Dental care | • Long-term care | • Weight loss programs |
| • Hearing aids (Adult) | | |

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) | • Chiropractic care | • Prescription Drugs |
| • Allergy testing | • Coverage provided outside the United States.
See Plan Document | • Private-duty nursing |
| • Bariatric Surgery | • Infertility treatment (limits apply) | • 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.

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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

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 íinízinigo t'áá diné k'éjúgo, t'áá shoodí ba na'ałníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daał iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

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

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Coverage Examples

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. 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. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,370
- Patient pays \$170

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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
Total	\$170

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

- Amount owed to providers: \$5,400
- Plan pays \$2,120
- Patient pays \$3,280

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	\$0
Coinsurance	\$0
Limits or exclusions	\$2,930
Total	\$3,280

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.