I. PLAN DESCRIPTIONS

A. POS—Point of Service

The Partnership Plan offers a single point of service plan to provide healthcare services both within and outside a defined network of Providers. No referrals are necessary to receive care from In-Network Providers. Healthcare services obtained outside the network may require precertification and are reimbursed at 80% of the allowable cost (after payment of the annual deductible). You will also pay 100% of the amount that your Out-of Network Provider bills above the Maximum Allowable Amount. Members using Out-of-Network services may also be subject to service limits that are not applicable to In-Network care. Using an Out-of-Network Provider will result in higher Member costs.

B. Health Enhancement Program

The Health Enhancement Program ("HEP") is an incentive program that rewards Members who commit to taking an active role in managing their health. Members who sign up for HEP will qualify for lower premiums, reduced Co-pays for certain services and medications, and waiver of annual deductibles on In-Network services. All family members enrolled in HEP must obtain age-appropriate preventive care and screenings; those with one or more chronic conditions (diabetes, asthma and COPD, heart failure or heart disease, hyperlipidemia, and hypertension) may be required to participate in counseling or condition management programs services.

Care Management Solutions, an affiliate of ConnectiCare Insurance Company, has been engaged to assist with monitoring Members' compliance with their HEP requirements and to provide disease and care management services to Members with chronic conditions.

Care Management Solutions
175 Scott Swamp Road
Farmington, CT 06034
877-687-1448

C. Carrier Contact Information

For information about Physicians and Providers Members can contact UnitedHealthcare/Oxford by calling the telephone number printed on your ID card or as follows:

UnitedHealthcare/Oxford
48 Monroe Turnpike
Trumbull, CT 06611-1341
1-800-385-9055

http://partnershipstateofct.welcometouhc.com/home

II. SCHEDULE OF BENEFITS

GENERAL	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Covered Person Upfront Deductible (Waived for HEP Members)	$350 per person, $1400 family maximum	Not Applicable
Out-of-Network Deductible	Not Applicable	$300 individual, $600 two person, $900 family
Out-of-Network Cost-Share (Coinsurance after meeting Deductible)	Not Applicable	20% of allowable charges + 100% of billed charges in excess of allowable charges
Lifetime Maximum	None	None
Person responsible for obtaining Prior Authorization	Participating Provider or Physician	Member
PREVENTIVE SERVICES	**Patient Share**	**Patient Share ▲**
Well Child Care:	No Co-pay	Deductible plus Coinsurance**
Adult Physical Exams:	No Co-pay	Deductible plus Coinsurance**
Preventive Gynecological Visit	No Co-pay	Deductible plus Coinsurance**
Mammography	No Co-pay	Deductible plus Coinsurance**
Immunizations and Vaccinations Includes those needed for travel	No co-pay	Deductible plus Coinsurance**
MEDICAL SERVICES	**Patient Share**	**Patient Share**
Primary Care Physician	$15 Co-pay	Deductible plus Coinsurance**
Specialist Physician (Includes in-office procedures)	$15 Co-pay	Deductible plus Coinsurance**
Vision exam and Refraction: 1 exam per calendar year (when performed as part of an exam)	$15 Co-pay	Deductible plus 50% Coinsurance** 1 exam per calendar year
Routine Hearing Screening: One per calendar year (when performed as part of an exam)	$15 Co-pay	Deductible plus Coinsurance**
Maternity Outpatient (first visit only)	$15 Co-pay	Deductible plus Coinsurance**

*Non-HEP members must satisfy In-Network Deductible to obtain services at no Co-pay.

** You will pay 20% of the Maximum Allowable Charge plus 100% of any amount your provider bills in excess of the allowable charge

GENERAL	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
MEDICAL SERVICES	**Patient Share**	**Patient Share**
Outpatient Surgery performed in hospital or licensed ambulatory surgery center (Includes colonoscopy) **(Prior Authorization required)**	No Co-pay*	Deductible plus Coinsurance**
Allergy Office Visit/Testing	$15 Co-pay	Deductible plus Coinsurance**
Allergy Injections Immunotherapy or other therapy treatments	No Co-pay*	Deductible plus Coinsurance**
Infertility Services		
Office Visit	$15 Co-pay	Deductible plus Coinsurance**
Outpatient Hospital	No Co-pay*	
Inpatient Hospital	No Co-pay*	
Gender Identity Disorder Services		
Office Visit	$15 Co-pay	Deductible plus Coinsurance**
Outpatient Hospital	No Co-pay*	
Inpatient Hospital	No Co-pay*	
HOSPITAL SERVICES	**Patient Share**	**Patient Share**
All Inpatient Admissions including Childbirth (Prior Authorization required)	No Co-pay*	Deductible plus Coinsurance**
Ancillary Services (Prior Authorization required)	No-Copay*	Deductible plus Coinsurance**
Specialty Hospital (Prior authorization required)	No Co-pay*	Deductible plus Coinsurance**
Utilization limit	None	60 days per covered person per calendar year
Skilled Nursing Facility (Prior authorization required)	No Co-pay*	Deductible plus Coinsurance**
Utilization limit	None	60 days per covered person per calendar year
Inpatient Hospice Care (Prior authorization required)	No Co-pay*	Deductible plus Coinsurance**
Utilization limit	None	60 days per covered person per calendar year
EMERGENCY/ URGENT CARE SERVICES	**Patient Share**	**Patient Share**
Emergency Room Treatment Waived if patient Admitted to hospital	$35 Co-pay	$35 Co-pay
Urgent Care Clinic	$15 Co-pay	Deductible plus Coinsurance**
Walk-in Clinic	$15 Co-pay	Deductible plus Coinsurance**
Emergency Ambulance	No Co-pay*	No Co-pay*

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** You will pay 20% of the Maximum Allowable Charge plus 100% of any amount your provider bills in excess of the allowable charge

GENERAL	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
OTHER HEALTHCARE SERVICES	**Patient Share**	**Patient Share**
High Cost Radiological & Diagnostic Tests: MRI, MRA, CAT, CTA, PET and SPECT scans **(Prior authorization required)**	No Co-pay*	Deductible plus Coinsurance**
Diagnostic, Laboratory and X-ray Services	No Co-pay*	Deductible plus Coinsurance**
Radiation Therapy	No Co-pay*	Deductible plus Coinsurance**
Nutritional Counseling Maximum of 3 visits per Covered Person per Calendar Year	No Co-pay*	Deductible plus Coinsurance**
Private Duty Nursing (Prior Authorization Required)	No Co-pay*	Deductible plus Coinsurance**
Home Health Care **Utilization Limits**	No Co-pay* 200 visits per calendar year	Deductible plus Coinsurance** 200 visits per calendar year
In-Home Hospice	No Co-pay*	Deductible plus Coinsurance** 200 visits per calendar year
Acupuncture **Limit: 20 visits per calendar year**	$15 Co-pay	Deductible plus Coinsurance** (Prior Authorization required)
Infusion Therapy Unlimited	No Co-pay*	Deductible plus Coinsurance**
OUTPATIENT REHABILITATION SERVICES	**Patient Share**	**Patient Share**
Physical or Occupational Therapy **Prior Authorization may be required** **Benefit limit**	No Co-pay* Unlimited	Deductible plus Coinsurance** 30 visits per calendar year
Chiropractic Therapy **Benefit Limit**	No Co-pay* Unlimited	Deductible plus Coinsurance** 30 visits per calendar year
Speech therapy: Covered only for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx **Benefit limit:**	No Co-pay* Unlimited	Deductible plus Coinsurance** 30 visits per Calendar Year
Autism Services: Behavioral, Outpatient, Rehabilitation, Physical, occupational, and speech therapy	No Co-pay*	Deductible plus Coinsurance**
Other Therapy Services: Radiation, Chemotherapy for treatment of cancer, Electroshock, Kidney Dialysis in Hospital or free-standing dialysis center	No Co-pay*	Deductible plus Coinsurance**

*Non-HEP members must satisfy In-Network Deductible to obtain services at no Co-pay.** You will pay 20% of the Maximum Allowable Charge plus 100% of any amount your provider bills in excess of the allowable charge

GENERAL	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
MEDICAL DEVICES/SUPPLIES	**Patient Share**	**Patient Share**
Home Oxygen **Diabetic equipment and supplies**	No Co-pay	Deductible plus Coinsurance**
Specialized Formula **(Prior Authorization required)**	No Co-pay	Deductible plus Coinsurance**
Wig—Covered only for patient who suffers hair loss as result of chemotherapy)	No Co-pay	No Co-pay
Foot Orthotics	No Co-pay	Deductible plus Coinsurance**
Durable Medical Equipment and Prosthetic Devices **(Prior Authorization may be required)**	No Co-pay	Deductible plus Coinsurance**
Medical and Ostomy Related Services	No Co-pay	Deductible plus Coinsurance**
MENTAL HEALTH & SUBSTANCE ABUSE	**IN-NETWORK** **Patient Share**	**OUT-OF-NETWORK** **Patient Share**
Outpatient Treatment for Mental Health Care **(Prior Authorization required)**	$15 Co-pay	Deductible plus Coinsurance**
Inpatient Treatment In a Hospital or Residential Treatment Center for Mental Health Care **(Prior Authorization required)**	No Co-Pay*	Deductible plus Coinsurance**
Outpatient: Substance Abuse **(Prior Authorization required)**	$15 Co-pay	Deductible plus Coinsurance**
Inpatient Substance Abuse Treatment In a Hospital or Substance Abuse Treatment Facility **(Prior Authorization required)**	No Co-Pay*	Deductible plus Coinsurance**
PENALTY		
Penalty for Failure to Obtain Prior Authorization for Covered Services		$500 or 20% of allowable charges, whichever is less, plus 100% of billed amount in excess of allowable charges

*Non-HEP members must satisfy In-Network Deductible to obtain services at no Co-pay.** You will pay 20% of the Maximum Allowable Charge plus 100% of any amount your provider bills in excess of the allowable charge