

Visit www.osc.ct.gov/ctpartner [click “provider networks”] to search the list of network providers.

Administered by
UnitedHealthcare/Oxford

IN NETWORK

CT Partnership Plan 2.0
w/ Health Enhancement Program

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 High Cost Radiological & Diagnostic Tests	\$0 Co-pay
Deductible	Individual: \$350 Family: \$350 each member (\$1,400 maximum). Waived for HEP-compliant members.
Coinsurance	Not applicable
Max out of pocket	\$2,000 individual / \$4,000 family

PREVENTIVE SERVICES

CT Partnership Plan 2.0
w/ Health Enhancement Program

Primary Care (Adult and Child Wellness Exams)	\$0 Co-pay
Gynecologist Wellness	\$0 Co-pay
Mammogram	\$0 Co-pay
Lifetime Maximum	Unlimited

OUT OF NETWORK

CT Partnership Plan 2.0
w/ Health Enhancement Program

Annual Deductible	\$300 individual/\$900 family
Coinsurance	20% of allowable UCR charges
Max Out-of-Pocket	\$2,300 individual / \$4,900 family
Lifetime Maximum	Unlimited

CONNECTICUT PARTNERSHIP PLAN 2.0

MEDICAL BENEFIT SUMMARY

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OTHER SERVICES

CT Partnership Plan 2.0 w/ Health Enhancement Program

Deductible	Not applicable*
Acupuncture (20 visits/year)	\$15 Co-pay
Chiropractic	\$0 Co-pay
Nutritional Counseling (3 visits/year)	\$0 Co-pay
Physical/Occupational Therapy	\$0 Co-pay
Durable Medical Equipment	\$0 Co-pay
Routine Hearing Screening (as part of an exam)	\$15 Co-pay

PRESCRIPTION COVERAGE

MAINTENANCE DRUGS

NON-MAINTENANCE DRUGS

HEP CHRONIC CONDITION DRUGS

Generic	\$5	\$5	\$0
Preferred/Listed Brand Name	\$10	\$20	\$5
Non-Preferred/Non-Listed Brand Name	\$25	\$35	\$12.50
Annual Maximum	Unlimited		
Max out of pocket	\$4,600 individual / \$9,200 family		

UnitedHealthcare/Oxford Contact Information

Live, knowledgeable customer service representatives are available for current State of Connecticut Partnership members toll-free at **800-385-9055** from 8am to 6pm EST, Monday through Friday.

If you prefer, you may also visit <http://partnershipstateofct.welcometouhc.com> to search for a participating physician or facility, to learn about your health plan, to find the status of claims, or obtain additional information about discount programs offered to State of Connecticut Partnership members.

UnitedHealth Allies: This health discount program helps you, and your family, save money on many health and wellness purchases not included in your standard health benefit plan.

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Vision Rider

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Materials Co Pay	\$0	N/A
Single Vision Lenses	Covered in Full	\$40 Allowance
Bifocal Lenses	Covered in Full	\$65 Allowance
Trifocal Lenses	Covered in Full	\$75 Allowance
Lenticular Lenses	Covered in Full	\$100 Allowance
Contact Lenses (Retail Allowance)		
Elective	\$360 Allowance	\$345 Allowance
Therapeutic	Covered in Full	\$345 Allowance
Frame (Retail Allowance)	\$175 Allowance	\$126 Allowance

CONNECTICUT PARTNERSHIP PLAN



DENTAL BENEFIT SUMMARY

Administered by Cigna

	\$1,500 Annual Maximum Plan	Dental HMO Plan
	IN/OUT NETWORK	
Annual Deductible	\$0	\$0
Annual Maximum	\$1,500	none
Lifetime Orthodontia Max	\$1,500	covered*
DEDUCTIBLE WAIVED		
Preventive	Yes	N/A
Basic	N/A	N/A
Major	N/A	N/A
PREVENTATIVE		
X-Ray	100%	100%
Cleanings	100%	100%
Oral Exam	100%	100%
Flouride	100%	100%
BASIC		
Fillings	80%	covered*
Endodontics	80%	covered*
Periodontics	80%	covered*
Simple Extractions	80%	covered*
Dentures (Repair Only)	80%	covered*
Bridges (Repair Only)	80%	covered*
MAJOR		
Crown	67%	covered*
Inlays	67%	covered*
Onlays	67%	covered*
Dentures	67%	covered*
Bridges	67%	covered*
Space Maintainers	100%	covered*
Oral Surgery	67%	covered*
ORTHODONTIA		
Braces (Adult & Child)	50% Child Only	covered*

* visit www.osc.ct.gov/CTPartner to view full Dental HMO Benefit Plan

	Birth – age 5	Age 6 - 17	Age 18 – 24	Age 25 – 29	Age 30 – 39	Age 40 – 49	Age 50+
Preventive Service	Birth – age 5	Age 6 - 17	Age 18 – 24	Age 25 – 29	Age 30 – 39	Age 40 – 49	Age 50+
Preventive Visit	Once per year	Once every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50 - 64 - Every 3 years 65 and Over - Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years starting at 20	Every 5 years	Every 5 years	Every 5 years	Every 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	One screening between the ages of 35 and 39. Otherwise as recommended by physician	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years starting at age 21	Every 3 years	Every 3 years	Every 3 years	Every 3 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT to age 75

These requirements meet compliance with the HEP Preventive Program as outlined in the SEBAC agreement and have not changed from 2012.

As is currently the case under the State Health plan, any medical decisions will continue to be made by you and your physician