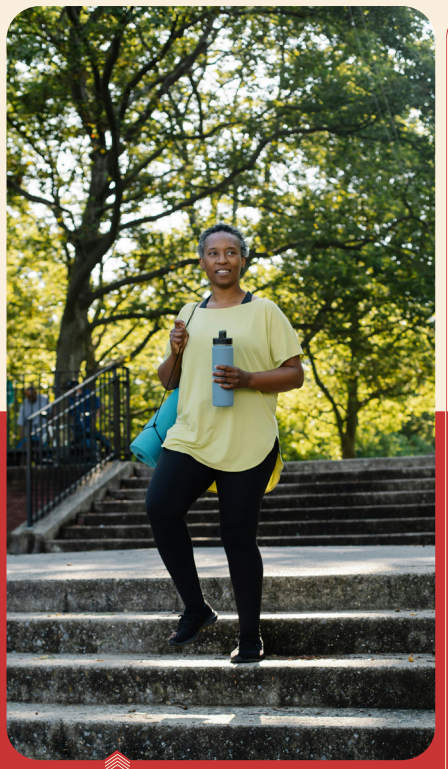
2025
2026

CARE COMPASS

HEALTH CARE OPTIONS PLANNER

FOR STATE OF CONNECTICUT RETIREES

YOUR *life*



YOUR *health*

YOUR *benefits*

Produced by the Office of the State Comptroller,
Administrator of the State of Connecticut Health Plan.

YOUR *online benefits resource:*
carecompass.ct.gov

Using Your Retiree Health Care Options Planner

To use this Planner effectively, be sure you're reviewing the correct section. Information is organized into coverage for non-Medicare-eligible individuals (starting on **page 11**) and coverage for Medicare-eligible individuals (starting on **page 28**). Within each section, benefit information is grouped by retirement date. Your retirement date falls into one of the following groups:

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 or later
- **Group 6:** Retirement date October 2, 2017 – July 1, 2022 (fewer than 25 years of service OR non-hazardous duty)
- ***Group 7:*** *Senior Judges and Trial Referees, (Not Included in Retiree Benefits, See Active Employee Benefits)*
- **Group 8:** Retirement date August 1, 2022 or later (Hazardous Duty)
- **Group 9:** Retirement date August 1, 2022 or later (Non- Hazardous Duty)

Before you begin, determine which group you belong to.

While you may be eligible for Medicare, and therefore enrolled in the Aetna Medicare Advantage plan, your covered dependents may not be eligible for Medicare. If that is the case, they can choose a non-Medicare-eligible medical plan. Please pay careful attention to the differences between Medicare-eligible and non-Medicare-eligible coverage.

You may need to review coverage options in both the non-Medicare-eligible section and the Medicare-eligible section, depending on your and your dependents' Medicare eligibility.

Sean Scanlon
State Comptroller
@CTComptroller

Welcome!

Congratulations on your retirement! We truly appreciate all the hard work and dedication you've had throughout your career.

It's our privilege to offer retiree health care coverage to you and your eligible family members. Your eligibility for Medicare will impact the coverage options available to you in retirement. If you're not yet eligible for Medicare, you can continue the same coverage you had as an active employee, or choose a different plan. If you're eligible for Medicare, you have one health care plan available to you: the Aetna Medicare Advantage PPO.

Review this Planner carefully to learn about the coverages available to you and your family members and how they interact with Medicare.

Sean Scanlon
Connecticut State Comptroller

Want to learn more? Visit...
carecompass.ct.gov/benefits-enrollment
for live Q&A events, helpful quizzes, and more.

TABLE OF CONTENTS

Your 2025 Open Enrollment Checklist

Open Enrollment for State of Connecticut dental plans and non-Medicare health plans is **May 1 through May 31, 2025**, for benefits effective July 1, 2025. Complete this checklist before the May 31 deadline to get a better understanding of the 2025 changes and to make updates to your coverage, if needed.

Your Open Enrollment Checklist

- [x] Use this Planner to review coverage and the premium amounts for medical and dental coverage (**pages 9-10**).

- [ ] Pay careful attention to the *What's New Starting July 1, 2025* section on **page 2**. It provides an overview of the 2025 changes to your health care coverage.

- [ ] Make changes if you need to by completing the Retiree Health Enrollment/ Change Form (CO-744-OE) on **page 45** of this planner. Be sure to

  1. Select the type of change you're requesting.
  2. List all dependents you're covering and provide supporting documentation for new dependents.
  3. Sign your application.
  4. Cut out the application from the back of the Planner, and return it via U.S. mail, email or fax to:

     Office of the State Comptroller
     ATTN: Retiree Health Insurance Unit
     165 Capitol Avenue
     Hartford, CT 06106

     Email: osc.rethealth@ct.gov **Fax:** 860-702-3556

If you have no changes...

Review this Retiree Health Care Options Planner. If you decide not to make changes to your coverage, **DO NOT** complete the Retiree Health Enrollment/Change Form (CO-744-OE). Your current coverage will continue automatically.

If you have questions...

Call the Office of the State Comptroller, Retiree Health Insurance Unit at **860-702-3533**. For more information about Open Enrollment, go to **carecompass.ct.gov**. Non-Medicare retirees on an Anthem plan may contact a personal Care Coordinator at **833-740-3258**.

2025 Open Enrollment Overview

Open Enrollment: May 1-May 31, 2025
Changes Effective: July 1, 2025 through June 30, 2026

Open Enrollment gives you the opportunity to change your health care benefit elections and your covered dependents for the coming plan year. It's a good time to take a fresh look at the plans available to you, consider how your and your family's needs may have changed, and choose coverage that offers the best value for your situation.

During Open Enrollment, you can change medical (non-Medicare-eligible retirees only) or dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage. If you or a covered dependent is not eligible for Medicare, you can select a new non-Medicare-eligible medical plan during the Open Enrollment period.

No changes this year?

If you want to keep your current coverage elections, you **DO NOT** need to complete the Retiree Health Enrollment/Change Form (CO-744-OE). Your coverage will continue automatically.

There are no significant benefit changes for 2025. If you don't want to change your coverage, it will automatically roll over at the applicable 2025/2026 premiums.

If you are NOT eligible for Medicare...	If you ARE eligible for Medicare...
You can enroll in or change your selection to one of these medical plans:	You CANNOT...
• Quality First Select Access (State BlueCare Prime Tiered POS) (available only to Connecticut residents) • Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus]) • Standard Access (State BlueCare Point of Enrollment [POE]) • Expanded Access (State BlueCare Point of Service [POS]) • *State Preferred Point of Service (POS)* (closed to new enrollment) • Out-of-Area (available only if retiree's permanent address is outside Connecticut)	• Make a change to your medical coverage until the Medicare Open Enrollment period in October 2025. You will receive more information prior to the Medicare Open Enrollment period.
You can...	You can...
• Enroll in or make changes to your non-Medicare-eligible medical plan (listed above) • Add or change your dental plan option • Add or drop dependents from medical and dental coverage	• Add or change your dental plan option • Add or drop dependents from medical and dental coverage
...by submitting by May 31...	...by submitting by May 31...
• A completed Retiree Health Enrollment/Change Form (CO-744-OE) • Any required documentation supporting the addition of an eligible dependent	• A completed Retiree Health Enrollment/Change Form (CO-744-OE) • Any required documentation supporting the addition of an eligible dependent

Once you choose a health plan, you cannot change plans until the next Open Enrollment. The exception is if you have a qualifying status change, such as moving out of the plan's service area or becoming eligible for Medicare (in which case you must enroll in the Aetna Medicare Advantage plan). You cannot change plans if your doctor or hospital leaves the health plan. More information about qualifying status changes is on **pages 6 and 7**.

Benefit Options

Dental Plans

- Total Care DHMO Plan
- Enhanced Plan
- Basic Plan

Before changing your dental plan, be sure your dentist is in-network for your selected plan by contacting Cigna or visiting **Carecompass.ct.gov/benefits-enrollment**.

Non-Medicare-Eligible Medical Plans

- Primary Care Access
  State BlueCare Network (POE Plus)
- Standard Access
  State BlueCare Network (POE)
- Expanded Access
  State BlueCare Network (POS)
- Quality First Select Access
  State BlueCare Network (Tiered POS)

NOTE! The Dental DHMO Plan and Preferred Plan (medical) are closed to new enrollment. If currently enrolled, you can stay or choose to move to another plan.

Open Enrollment Resources

Care Compass

Care Compass is your home for all benefits information. It serves as a comprehensive online source of information on the state's health plan, including medical, dental, pharmacy, and supplemental benefit options.

Visit carecompass.ct.gov for information about medical, pharmacy and dental benefits. Select "Retiree" in the navigation bar.

Care Coordinators

Non-Medicare retirees, their spouses, and adult dependents can connect with a personal Care Coordinator for help understanding their benefits and to coordinate between all programs and partners. Care Coordinators can help with:

- Healthcare management
- HEP Assistance
- Plans & Claims Support

Call a Care Coordintor at 833-740-3258, or log in to your benefits portal (carecompass.quantum-health.com) to send a secure message or live chat with a Care Coordinator.

Your Personal Benefits & HEP Portal

For a completely personalized benefits experience, non-Medicare retirees can use the benefits portal (from Quantum Health) accessible from **carecompass.ct.gov** or the **MyQHealth app**. The portal includes:

- A provider search tool built to help you locate in-network providers in your plan. Search by provider name, facility, location, or specialty. From the portal, select **My Plan > Find Provider.**
- One-click access to personalized pharmacy, medical and dental websites.
- A one-stop shop for all of your benefit needs, like digital ID cards and claims information.
- Personalized assistance from Care Coordinators. They're standing by to help!

To access and register for your benefits portal:

- Go to **Carecompass.ct.gov** and select Benefits Login. Then, register using the last four digits of your Medical ID (found on your Anthem card).
- You may also download the free mobile app by searching for "**MyQHealth**" at the App Store or on Google Play. If you haven't registered on the site, click **Register** and follow the steps.
- Adult dependents (age 18 and over) can register for a personal benefit account. You can share your HEP status with a family member by creating your own account, clicking Profile Settings, and selecting the Wellness/Prevention box.

Enrolling in Retiree Health Benefits

2025 Open Enrollment: May 1 through May 31, 2025
Coverage effective July 1, 2025 through June 30, 2026.

Current Retirees

If no changes are needed: You do not need to complete an enrollment form unless you are changing non-Medicare medical coverage, dental coverage, or your covered dependents. Your current benefits will continue automatically.

If you want to make changes: To make changes to dental coverage or non-Medicare-eligible medical coverage (if applicable), follow the Open Enrollment Checklist on **page 1**. Fill out the Retiree Health Enrollment/Change Form (CO-744-OE) on **page 45** of this Planner and return it to the Retiree Health Insurance Unit.

New Retirees

Your health coverage as an active employee does NOT automatically transfer to your coverage as a retiree. You must enroll if you want retiree health coverage for yourself and any eligible dependents. To enroll for the first time, follow these steps:

- Review this Planner and choose the medical and dental options that best meet your needs.
  Note: If you are Medicare-eligible, there is only **one** medical plan option.
- Complete the Retiree Health Enrollment/Change Form (CO-744) included in your retirement packet.
  Note: **This is different from the form on page 45.**
- Return the completed form and any necessary supporting documentation to the Office of the State Comptroller at the address shown on the form.

You must complete your enrollment in retiree health coverage within **30 calendar days** after your retirement date. If you do not enroll within 30 days, you must wait until the next Open Enrollment to enroll in retiree coverage.

If you enroll as a new retiree, your coverage begins the first day of the second month of your retirement. For example, if your retirement date is October 1, your coverage begins November 1.

Important! **If you are Medicare-eligible, you must be enrolled in Medicare to enroll in the State of Connecticut Retiree Health Plan.** If you are age 65 or older, contact Social Security at least three months before your retirement date to learn about enrolling in Medicare.

Waiving Coverage

If you have other medical coverage and want to waive State of Connecticut coverage when first eligible, you can choose to enroll later, within within 30 days of losing your other coverage or during Open Enrollment.

To waive coverage, retirees must complete the Retiree Health Enrollment/Change Form (CO-744-OE), check "Waive Medical Coverage," and return it to the Retiree Health Insurance Unit.

Important! **If you waive coverage, you cannot enroll dependents under the State Retiree Health Plan. You must be enrolled yourself to cover eligible dependents.**

Medicare Enrollment

Retiree members and dependents covered by the State of Connecticut Retiree Health Plan must be enrolled in Medicare as soon as they are eligible due to age, disability or end−stage renal disease (ESRD).

Eligibility for Retiree Health Benefits

Retiree

You must meet age and minimum service requirements to be eligible for retiree health coverage. Service requirements vary. For information about eligibility for retiree health benefits, contact the Retiree Health Insurance Unit at 860-702-3533.

Dependent

You can cover dependents under your medical and dentals plans. It is your responsibility to only enroll eligible dependents to avoid financial consequences. Eligible dependents are generally:

- Your legally married spouse or civil union partner
- Your children through the end of the year they turn 26
- Children living with you for whom you are the legal guardian (to age 18, unless proof of continued dependency is provided)
- Disabled children over age 26. Contact Quantum Health at 833-740-3258 to verify your child's eligibility. Once you enroll your disabled adult child, they must remain enrolled to retain eligibility. Your disabled child must meet the following requirements for continued coverage:
  - Adult child is enrolled in a State of Connecticut employee plan on the child's 26th birthday. (Not required if you are a new retiree enrolling for the first time.)
  - Disabled child must meet the requirements of being an eligible dependent child before turning age 26. (Not required if you are a new retiree enrolling for the first time.)
  - Adult child must have been physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled since age 26.
  - Adult child is dependent on the member for substantially all of their economic support and is declared as an exemption on the member's federal income tax return.
  - Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter and upon request.
  - All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify the Retiree Health Insurance Unit of any dependent's eligibility for, and enrollment in, Medicare.

Retiree Health Enrollment/Change Form
(CO-744-OE)
page 45 or at carecompass.ct.gov

You will need to provide documentation to confirm an eligible relationship when enrolling a family member.

It is your responsibility to notify the Retiree Health Insurance Unit within 30 days after the date when any dependent is no longer eligible for coverage. For more information about enrolling dependents, see **"Making Changes to Your Coverage During the Year"** on **page 6**.

Retirees and dependents may be enrolled in different plans (depending on Medicare eligibility)

All State of Connecticut Retiree Health Plan members who are eligible for Medicare are automatically enrolled in the Aetna Medicare Advantage PPO plan. **If you have enrolled dependents who are not yet eligible for Medicare** (typically, those under age 65), their current medical and prescription drug coverage will stay the same. This means that some retirees and dependents will be enrolled in different plans. This is also referred to as a "split family."

Making Changes to Your Coverage During the Year

Once you pick your medical (for non-Medicare-eligible retirees) and dental plans, you can't make changes during the plan year unless you have a qualifying life event, as defined by the IRS.

If you do have a qualifying event, you must notify the Retiree Health Insurance Unit and submit a Retiree Health Enrollment/Change Form (CO-744) within 30 days. If you miss the 30-day window, you'll have to wait until the next Open Enrollment to make changes.

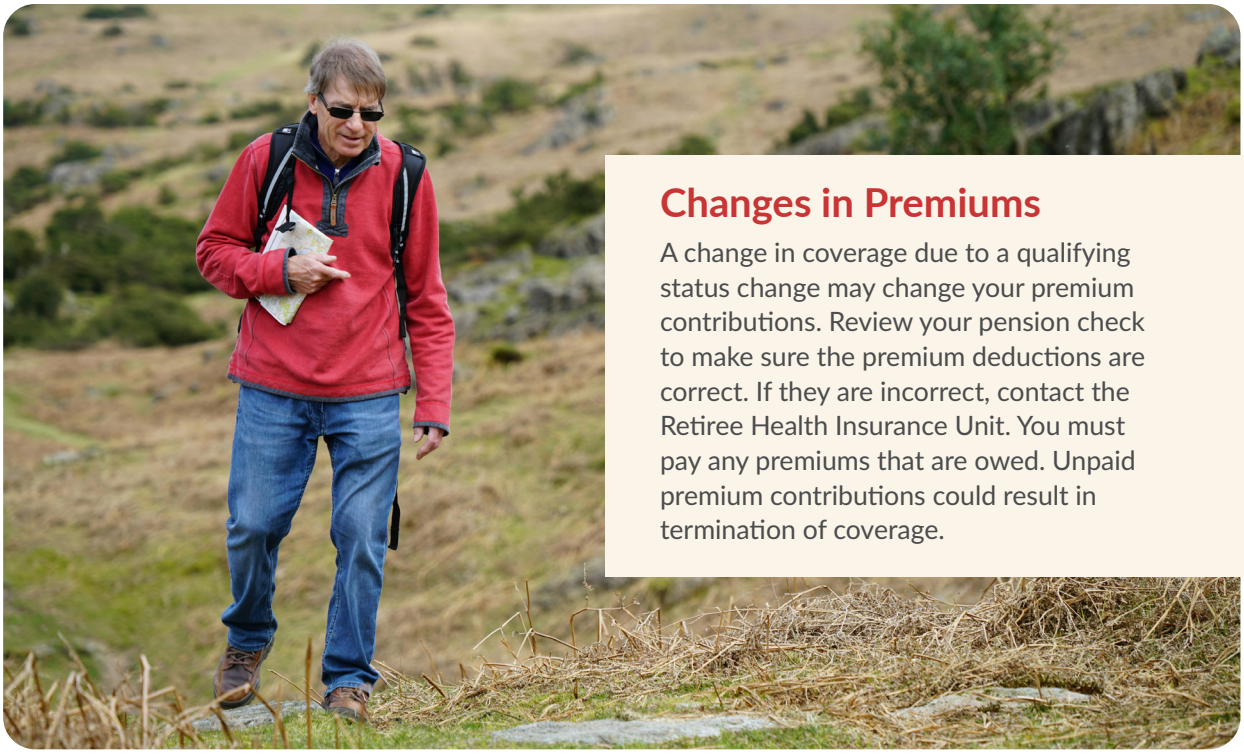
Any changes must match your change in status. A list of qualifying events and the required documents is on **page 7**.

Death of a Retiree

If you die, your surviving dependents or designee should contact the Retiree Health Insurance Unit to obtain information about their eligibility for survivor health benefits. To be eligible, your surviving spouse must have been married to you at the time of your retirement and must continue to receive your pension benefit after your death. After the Retiree Health Insurance Unit is notified of your death, your surviving spouse will receive further information.

Review Your Dependent Coverage

If an enrolled dependent is no longer eligible for coverage under the State of Connecticut Retiree Health Plan, you must immediately notify the Retiree Health Insurance Unit. **If you are legally separated or divorced, your spouse/former spouse is not eligible for coverage. This information is subject to audit.**



Changes in Premiums

A change in coverage due to a qualifying status change may change your premium contributions. Review your pension check to make sure the premium deductions are correct. If they are incorrect, contact the Retiree Health Insurance Unit. You must pay any premiums that are owed. Unpaid premium contributions could result in termination of coverage.

Qualifying Status Change	Required Documents	Coverage Date
Marriage or civil union	• Completed enrollment application • Marriage Certificate or state-issued Civil Union Certificate • Previous Year IRS Form 1040 • Proof of Medicare enrollment (if applicable)	First day of the month following the event date
Birth or adoption	• Completed enrollment application • Long Form Birth Certificate • (for adoptive parents) Notification of Placement for Adoption from the adoption agency, or certified copy of the Adoption Decree • (for step-parents) Marriage Certificate • Previous Year IRS Form 1040	Newborn child: First of the month following the child's date of birth Adopted child: The date the child is placed with you for adoption
Legal guardianship or court order	• Completed enrollment application • Court documentation granting Legal Guardianship • Form CO-1318	The first day of the month following the submission of proof of the event or court order
Divorce or legal separation	• Completed enrollment application • Copy of the legal documentation of your family status change	Coverage will terminate on the first day of the month following the date on which the divorce or legal separation occurred
By law, you must disenroll ineligible dependents within 31 days after the date of a divorce or legal separation. Failure to notify the Retiree Health Insurance Unit can result in significant financial penalties.		
Loss of other health coverage	• Completed enrollment application • Proof of loss of coverage (documentation must state the date your other coverage ends and the names of individuals losing coverage)	First of the month following your loss of coverage
Obtaining other health coverage	• Completed enrollment application • Proof of enrollment in other health coverage (documentation must indicate the effective date of coverage and the names of enrolled individuals)	Coverage will terminate on the first of the month following the event date. Note: You must pay premium contributions up to the termination date of your retiree health coverage
Moving out of your plan's service area (non-Medicare-eligible coverage only)	Address Change Form (CO-1082), available at: **osc.ct.gov**	Coverage under the new plan will be effective the first of the month following the date you permanently moved
If you or a covered dependent has Medicare-eligible coverage, you must live in the U.S. in order to be covered by the plan.		
Death of a dependent	Copy of the death certificate	Coverage terminates the day after the dependent's death

Cost of Coverage

Once you are enrolled, premium contributions are deducted from your monthly pension check. Review your pension check to verify that the correct premium contribution is being deducted. If your pension check does not cover your required premiums, or you do not receive a pension check, you will be billed monthly for your premium contributions. Premium contribution deductions are shown on **pages 9 and 10**.

All Medicare-eligible retirees and dependents must maintain continuous enrollment in Medicare. To ensure there is no break in your medical coverage, you must pay all Medicare premiums that are due to the federal government on time. You will continue to be reimbursed for your Medicare Part B and IRMAA premium amounts as long as the state has a copy of your Medicare card and annual premium notice on file.

Calculating Your Medical Premium Contribution Rate

All Covered Individuals Eligible for Medicare

If you and all covered dependents are eligible for Medicare, you will pay nothing for your medical and prescription drug coverage offered through the State of Connecticut Retiree Health Plan.

Split Families: Some Eligible for Medicare, Some Not

If one or more members are eligible for Medicare and one or more members are not (known as "Split Family"), you will need to calculate how much you will pay for coverage on a monthly basis. Here's how:

1. You will pay nothing for Medicare-eligible individuals enrolled in medical and prescription drug coverage under the State of Connecticut Retiree Health Plan.
2. For all non-Medicare-eligible individuals, you will pay medical premium contributions only if you are enrolled in a plan that requires monthly premium contributions.

Review the **Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage** section on **page 9** to see if you or your dependents are covered under a plan that requires premiums. If yes, determine your monthly premium amount by identifying the number of individuals covered under that plan.

All Covered Individuals Not Eligible for Medicare

You'll only pay medical premiums if you or your dependents are enrolled in a plan that requires monthly contributions.

Check the **"Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage"** section on **page 9** to see if your plan requires a premium. If it does, find your monthly cost based on the number of individuals covered.

If You Retired Early

If you retired early, you may pay additional retiree premium share costs per the 2011 SEBAC agreement. For additional information, please contact the Retiree Health Insurance Unit at **860-702-3533**.

Higher Premiums Without HEP

If your retirement date is October 2, 2011 or later, you are eligible for the Health Enhancement Program (HEP). **See pages 21 – 22**.

Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage

Coverage Level	Quality First Select Access* (State BlueCare Prime Tiered POS)	Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus])	Standard Access (State BlueCare Point of Enrollment [POE])	Expanded Access (State BlueCare Point of Service [POS])	Anthem State Preferred POS**	Anthem Out-of-Area
Group 1: Retirement date prior to July 1999						
1 person	$0	$0	$0	$0	$0	$0
2 persons	$0	$0	$0	$0	$0	$0
3+ persons	$0	$0	$0	$0	$0	$0
Group 2: Retirement date 7/1/99 – 5/1/09, and those under the 2009 RIP						
1 person	$22.06	$0	$0	$23.11	$24.60	$0
2 persons	$48.53	$0	$0	$50.84	$54.11	$0
3+ persons	$59.55	$0	$0	$62.40	$66.41	$0
Group 3: Retirement date 6/1/09 – 10/1/11						
1 person	$22.06	$0	$0	$23.11	$24.60	$0
2 persons	$48.53	$0	$0	$50.84	$54.11	$0
3+ persons	$59.55	$0	$0	$62.40	$66.41	$0
Group 4: Retirement date 10/2/11 – 10/1/17						
1 person	$22.06	$0	$0	$23.11	$24.60	$0
2 persons	$48.53	$0	$0	$50.84	$54.11	$0
3+ persons	$59.55	$0	$0	$62.40	$66.41	$0
Group 5: Retirement date 10/2/17 – 7/1/2022; 25 or more years of service OR hazardous duty						
1 person	$21.44	$0	$0	$22.01	$23.45	$0
2 persons	$47.16	$0	$0	$48.41	$51.60	$0
3+ persons	$57.88	$0	$0	$59.42	$63.33	$0
Group 6: Retirement date 10/2/17 – 7/1/2022; fewer than 25 years of service OR non-hazardous duty						
1 person	$42.87	$21.38	$21.58	$44.01	$46.91	$23.45
2 persons	$94.32	$47.04	$47.48	$96.83	$103.20	$51.60
3+ persons	$115.76	$57.74	$58.27	$118.83	$126.65	$63.33
Group 8: Retirement date August 1, 2022 or later; hazardous duty						
1 person	$42.87	$42.77	$43.16	$44.01	$46.91	$46.91
2 persons	$94.32	$94.09	$94.96	$96.83	$103.20	$103.20
3+ persons	$115.76	$115.47	$116.54	$118.83	$126.65	$126.65
Group 9: Retirement date August 1, 2022 or later; non-hazardous duty						
1 person	$71.46	$71.28	$71.94	$73.35	$78.18	$78.18
2 persons	$157.21	$156.81	$158.27	$161.38	$171.99	$171.99
3+ persons	$192.94	$192.45	$194.24	$198.06	$211.08	$211.08

**The Quality First Select Access plan is only available to employees (and their dependents) who live in Connecticut.*

*** Closed to new enrollment*

Monthly Dental Premium Contributions

You'll pay for the cost of dental coverage through deductions from your monthly pension check. Your premium contribution depends on the dental plan you choose, your retirement date and the number of covered individuals. Cigna is the administrator for all State of Connecticut dental plans.

Closed to new enrollments; the Total Care DHMO Plan offers better coverage and lower costs

Coverage Level	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan
All Retirement Groups				
1 person	$30.33	$40.12	$43.10	$24.32
2 persons	$66.72	$80.24	$86.21	$53.50
3+ persons	$81.89	$80.24	$86.21	$65.66

Using Your Benefits

Use these programs and tools to maximize your benefits and get help making important health care decisions. **It doesn't matter which medical plan you enroll in—you have access to all of these benefits regardless of your choice.**

When you need information about your benefits…

Check out **Carecompass.ct.gov**, your one-stop shop for state benefits, including benefit charts, plan documents, carrier contact information and more.

If you are a pre-65 (non-Medicare-eligible) retiree or dependent, you can utilize your personal benefits portal by registering or logging on from **carecompass.quantum-health.com**

You can also access your benefits portal by downloading the **MyQHealth app** (**App Store** or **Google Play**). If you registered on the website first, then just sign-in when accessing your portal on the app.

When you want to talk to a human...

Non-Medicare medical plan retirees and their dependents can speak directly with a personal Care Coordinator, a real person there to help you understand your benefits.

Call 833-740-3258, Monday – Friday, 8:30 a.m. – 10 p.m.

Care Coordinators are here to help you understand your coverage, find doctors, and navigate the complexities of health care. You can contact them by phone or send secure messages through the benefits portal provided by Quantum Health.

Whether online or over the phone, Care Coordinators work directly with Anthem, Cigna, and CVS Caremark to simplify your benefits and help you get the care you need, when you need it.

Coverage for

Individuals NOT Eligible *for* Medicare

Medical Coverage

As a non-Medicare-eligible retiree or dependent, you have access to the same Anthem medical plans you had as an active employee:

- **Quality First Select Access (State BlueCare Prime Tiered POS):** This is the most affordable plan, with a smaller network of providers primarily in Connecticut and some nearby states. **Retirees and covered dependents must live in Connecticut to enroll.** As of October 1, 2024, Hartford Healthcare providers and facilities are included. No referrals are needed to see specialists.
- **Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G]):** A Primary Care Provider (PCP) is required in this plan; you must have a referral to see a specialist. Out-of-network services are not covered, except in an emergency.
- **Out-of-Area (OOA):** Only available if the retiree moves out of Connecticut.
- **Standard Access (State BlueCare Point of Enrollment [POE]):** This plan does not require referrals for specialists, or the selection of a Primary Care Provider (PCP). Out-of-network services are not covered, except in an emergency.
- **Expanded Access (State BlueCare Point of Service [POS]):** The most expensive plan, it allows you in- and out-of-network coverage. Out-of-network services are covered at 80% of the allowable charge.
- **State Preferred Point of Service (POS):** A Primary Care Provider (PCP) and referrals to specialists are not required. *Closed to new enrollment.*

Understanding the Plans

Choosing a medical plan might feel overwhelming, but it can be simple! All the medical plans cover the same medical benefits, services and supplies, just at different prices and with different networks.

Ask yourself these questions:

- Am I okay with selecting a primary care provider (PCP) to coordinate my care?
- Am I okay with seeking a referral before seeing a specialist?
- Do I need out-of-network options for care?
- Would I rather pay more in payroll deductions (premiums) or more out-of-pocket when I need care?
- Are my current providers in the network? Not sure? Visit **carecompass.ct.gov/benefits-enrollment** and use the **Find Provider** tool.

Once you've answered these questions, take a look at this table—it should help you narrow down your options.*

	Quality First Select Access	Primary Care Access	Standard Access	Expanded Access
Primary Care Physician	Not Required	Required	Not Required	Not Required
PCP Referral	Not Required	Required	Not Required	Not Required
Includes In- and Out-of-Network Coverage	Yes	No	No	Yes
Provider Network Size	Limited	Broad	Broad	Broad

Allowable Charge

If you visit an out-of-network provider, the allowable charge is the amount your plan would pay had you visited an in-network provider. When you visit an out-of-network provider, you are responsible for all charges above the allowable charge, up to that provider's usual charge for those services.

Need more help choosing a plan?

Call a Care Coordinator at **(833-740-3258)**, or visit **carecompass.ct.gov/decisionguide** to find easy-to-use decision-making tools!

Medical Coverage at a Glance

The table on the following pages shows the coverage available under the various medical plan options. As a reminder, the retirement groups are:

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 (25 or more years of service OR hazardous duty)
- **Group 6:** Retirement date October 2, 2017 – July 1, 2022 (fewer than 25 years of service OR non-hazardous duty)
- ***Group 7:*** *Senior Judges and Trial Referees, (Not Included in Retiree Benefits, See Active Employee Benefits)*
- **Group 8:** Retirement date August 1, 2022 or later (Hazardous Duty)
- **Group 9:** Retirement date August 1, 2022 or later (Non- Hazardous Duty)

The Quality First Select Access Plan

The Quality First Select Access plan (BlueCare Prime Tiered POS) lets you save on premiums by using a network of top-quality doctors, specialists, and facilities across Connecticut.

The State BlueCare Prime Tiered POS network was created to easily connect you with doctors and providers that offer the highest-quality care.

Retirees and covered dependents must live in Connecticut to enroll. The plan's network now includes Hartford Healthcare providers and facilities.

Visit **carecompass.ct.gov/benefits-enrollment** and use the **Find Provider** tool to see if your current PCP or specialists are in this plan's Connecticut-based network.

Quality First Select Access (State BlueCare Prime Tiered POS): All Groups

Your costs in this plan vary based on where you receive care. Use the chart below to compare coverage and out-of-pocket costs. **Note: You and your covered dependents must live in Connecticut to enroll in this plan.**

Benefit Features		Quality First Select Access		
		In-Network Value Tier 1	In-Network Tier 2	Out-of-Network[1]
Office/PCP telemedicine visit		You pay $0	PCP: You pay $50 Specialist: You pay $100	You pay 20%, plus deductible
LiveHealth Online (telemedicine)		You pay $0	N/A	N/A
Preventive care		You pay $0	You pay $0	You pay 20%, plus deductible
Walk-In Clinic/Urgent Care Center		You pay $35	You pay $35	You pay 20%, plus deductible
Emergency care (waived if admitted)		You pay $250	You pay $250	You pay $250
Diagnostic lab	Site of Service[3]	You pay $0	You pay $0	N/A
	Non-Site of Service	You pay 20%	You pay 20%	You pay 40%, plus deductible
Diagnostic x-ray (prior authorization required for diagnostic imaging)		You pay $0	You pay $0	You pay 20%, plus deductible
Inpatient physician/hospital (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient surgical facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Ambulance (if emergency)		You pay $0	You pay $0	You pay $0
Short-term rehabilitation and physical therapy (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Routine eye exam (one exam per year)		You pay $0	You pay $50	You pay 50%, plus deductible
Audiology screening (one exam per year)		You pay $0	You pay $50	You pay 20%, plus deductible
Inpatient Mental Health/Substance Abuse (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient Mental Health/ Substance Abuse		You pay $0	You pay $0	You pay 20%, plus deductible
Family planning: vasectomy or tubal ligation (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Durable medical equipment (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Skilled nursing facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Home health care (up to 200 visits per year; prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Annual deductible		$0[2]		Individual: $500[2] Family: $1,500[2]
Annual out-of-pocket maximum		Individual: $3,000 Family: $6,000		Individual: $6,000 Family: $12,000

[1]You pay coinsurance plus 100% of any amount your provider bills over the allowable charge (balance billing).

[2]Non-HEP Compliant: Additional $350 per individual; $1,400 maximum per family

[3]Site of Service doesn't apply to Groups 1-4

All Other Medical Plans: In-Network

- Expanded Access
- Primary Care Access
- Standard Access
- State Preferred Point of Service (POS)
  Closed to new enrollments
- Out-of-Area

Benefit Features	Group 1	Group 2	Group 3	Group 4	Group 5-9
Outpatient physician visit (PCP or specialist)					
Tier 1 provider[1,5]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Tier 2 provider[5]	You pay $5	You pay $15	You pay $15	You pay $15	You pay $15
Preventive care	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Emergency care	You pay $0	You pay $0	You pay $0	You pay $35[2]	You pay $250[2]
Diagnostic x-ray	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Diagnostic lab	You pay $0	You pay $0	You pay $0	You pay $0	Site of Service provider: You pay $0 Non-Site of Service provider: You pay 20%, plus deductible
Inpatient hospital care[3]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Outpatient surgery[3]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Ambulance (if emergency)	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Short-term rehabilitation and physical therapy[4]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Routine vision exam (1 exam per year)	You pay $15	You pay $15	You pay $15	You pay $15	You pay $15

[1] You may be eligible for a $0 copay by using a Tier 1 PCP or specialist.

[2] Emergency room copay waived if admitted; waiver form available for certain circumstances: carecompass.ct.gov/forms.

[3] Prior authorization may be required.

[4] Subject to medical necessity review.

[5] PCP telemedicine visits are covered the same as office visits

Continued on next page

All Other Medical Plans: In-Network *continued*

- Expanded Access
- Primary Care Access
- Standard Access
- State Preferred Point of Service (POS)
  Closed to new enrollments
- Out-of-Area

Benefit Features	*Group 1*	*Group 2*	*Group 3*	*Group 4*	*Group 5-9*
Routine hearing exam (1 exam per year)	You pay $15	You pay $15	You pay $15	You pay $15	You pay $15
Hearing aids[3] (1 set within a 36-month period)	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Inpatient Mental Health/Substance Abuse[3]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Outpatient Mental Health/ Substance Abuse	You pay $15	You pay $15	You pay $15	You pay $15	You pay $15
Skilled nursing facility (SNF)[3]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Durable medical equipment[3]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Home health care[3]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Hospice[3]	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Annual deductible	None	None	None	Individual: $350[6] Family: $350 per individual; $1,400 maximum per family[6]	Individual: $350[6] Family: $350 per individual; $1,400 maximum per family[6]
Annual medical out-of-pocket maximum	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000

[3] *Prior authorization may be required.*

[6] *Waived for HEP-compliant members.*

Out-of-Network

- State Preferred Point of Service (POS) **(Closed to new enrollments)**
- Out-of-Area

Benefit Features	*All Groups*[1]
Primary care physician office visit[2]	You pay 20%, plus deductible
Specialist office visit[2]	You pay 20%, plus deductible
Preventive services	You pay 20%, plus deductible
Emergency care[3]	Same copay as in-network
Diagnostic x-ray and lab	Groups 1 – 4: You pay 20%, plus deductible Group 5-7: You pay 0%, plus deductible
Inpatient hospital care[4]	You pay 20%, plus deductible
Outpatient surgery[4]	You pay 20%, plus deductible
Ambulance (if emergency)	You pay $0
Short-term rehabilitation and physical therapy[5]	You pay 20%, plus deductible (up to 60 inpatient days per condition per year; 30 outpatient days per condition per year)
Routine vision exam (1 exam per year)	You pay 50%, plus deductible
Routine hearing exam (1 exam per year)	You pay 20%, plus deductible
Hearing aids[4] (1 set within a 36-month period)	You pay 20%, plus deductible
Mental health and substance abuse treatment (inpatient and outpatient)[4]	You pay 20%, plus deductible
Durable medical equipment[4]	You pay 20%, plus deductible
Skilled nursing facility (SNF)[4]	You pay 20%, plus deductible (up to 60 days per year)
Home health care[4]	You pay 20%, plus deductible (up to 200 visits per year)
Hospice[4]	You pay 20%, plus deductible (up to 60 days per lifetime)
Annual deductible	Individual: $300 Family: $300 per individual; $900 maximum per family
Annual medical out-of-pocket maximum	Individual: $2,300 Family: $4,900

[1] You pay 20% of the allowable charge after the annual deductible, plus 100% of any amount your provider bills over the allowable charge (balance billing).

[2] You may be eligible for a $0 copay by using a Tier 1 PCP or specialist.

[3] Emergency room copay waived if admitted; waiver form available for certain circumstances: carecompass.ct.gov/forms.

[4] Prior authorization may be required.

[5] Subject to medical necessity review.

Using Your Benefits

In addition to the programs and tools described on **page 10**, Use these programs and tools to get the most out of your benefits, find the right provider, and avoid unnecessary costs. **It doesn't matter which medical plan you enroll in, all members in every plan have access to these benefits.**

When you need to find the best provider for your care…

You can easily find the providers with the highest patient care standards when you need specific procedures or treatment for certain conditions. The **"Providers of Distinction"** program is simple to use and rewards you for participating!

Earn incentives

If you select a Provider of Distinction for a qualifying procedure, you can earn an incentive! There are 300 eligible providers in Connecticut. The procedures include:

- Colonoscopy (you get $100)
- Endoscopy ($100)
- Hip Replacement ($500)
- Knee Arthroscopy ($150)
- Knee Replacement and Knee Revision ($500)
- Pregnancy and Delivery (prenatal care) ($250)
- Back and spine pain management ($100)
  The incentive is a one-time award for completing any one of three Back and Spine Pain Management programs.

To learn more about the program, visit **carecompass.ct.gov/providersofdistinction**.

Visit **carecompass.ct.gov/providersofdistinction** to search by procedure or provider, or call 833-740-3258 to speak with a personal Care Coordinator.

When you need routine lab work…

Lab tests (such as blood tests) are completely free to you ($0 copay) if you use one of many preferred labs, known as *Site of Service* providers. To find a nearby participating provider, contact a Care Coordinator or use the **Find Provider** tool on **carecompass.ct.gov.**

If you are not in Retirement Group 5, 6 or 7, you do not have a special designation for outpatient lab tests. Coverage will be provided according to the table on **pages 14–17**.

When you're traveling…

In the U.S.: You can use doctors and hospitals across the country in Anthem's BlueCard® program. In an emergency, you may need to pay upfront and submit documentation to Anthem for reimbursement.

International: Access care in nearly 200 countries through Blue Cross Blue Shield Global Core®. Call a Care Coordinator to set up coverage prior to your international travel.

Call a Care Coordinator for assistance or to arrange international coverage at 833-740-3258. If you're outside the U.S., call collect at 804-673-1177.

When moving hurts...

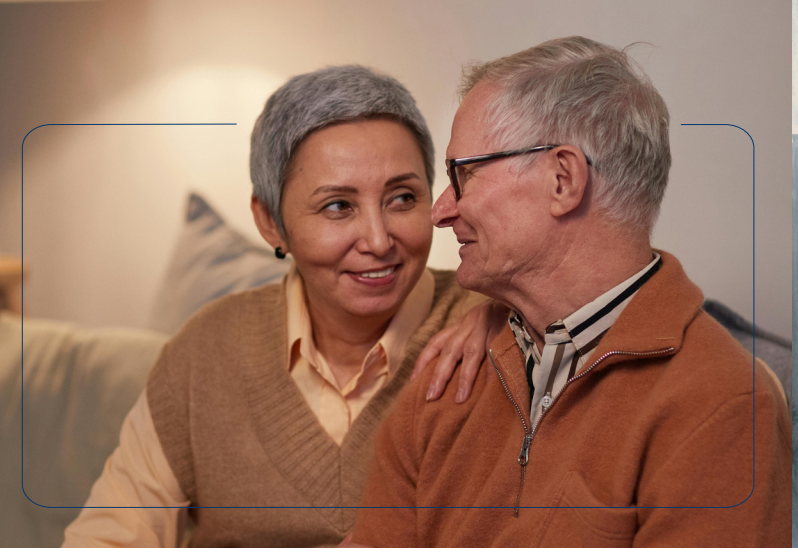
Get expert help with orthopedic injuries, from diagnosis of minor aches and pains, to surgery and recovery with virtual care options, in-person appointments, and a Spine Health program.

For orthopedic surgical procedures, find the best providers for the care you need. Learn more at **carecompass.ct.gov/orthopedics**.

When you need to take care of your mental health...

It's important to care for your mental and emotional health and your plan makes it easy to find providers and resources. Your benefits include coverage for behavioral health, substance use treatment, and addiction recovery.

Learn more at **carecompass.ct.gov/mental-health**.



Additional Programs

Additional programs are provided by Anthem and Quantum Health outside the contracted plan benefits. Because these programs are not plan benefits, they are subject to change at any time.

- **Access to a Care Coordinator:** You and any enrolled dependent can speak with a personal Care Coordinator (**833-740-3258**) for help understanding your benefits, finding a doctor, and dealing with the complexities of health care. **Quantum Health** coordinates with your medical, pharmacy, and dental member service teams, making it easier for you to get answers and guidance. Talk or chat with a Care Coordinator from **8:30 a.m. – 10 p.m., Monday – Friday,** or send a message through the secure portal.

- **Health benefits portal accessible on web and on an app:** You can register for the Benefits and HEP Portal at **carecompass.quantum-health.com**. The portal, powered by Quantum Health, makes it easy to manage your coverage and find the care you need. Access personalized information 24/7 from your phone, tablet, computer, or the MyQHealth app. Use the portal to connect with Care Coordinators, check claims, access digital ID cards, find providers, and more.

- **Monthly online well-being seminars:** Join 30-minute health seminars led by Wellspark professionals on topics like stress management, quitting smoking, boosting immunity, healthy eating, meditation, chair exercises, and more. Attending a "Basics" seminar can also satisfy your HEP Chronic Condition education requirement (if applicable). See the upcoming schedule of wellbeing seminars at **carecompass.ct.gov/wellbeing-seminars.**

- **Mental and behavioral health:** Find the programs and providers you need. Visit **carecompass.ct.gov/mental-health** or call a Care Coordinator to learn more.

- **Therapy services (medical review necessary):** Physical and occupational therapy services are subject to medical necessity review—a determination indicating whether your care is reasonable, necessary and/or appropriate based on your needs and medical condition. If you see an in-network provider, it is the provider's responsibility to submit all necessary information during the medical necessity review process.

- **Providers of Distinction:** You can easily find the providers with the highest patient care standards when you need specific procedures or treatment for certain conditions. The "Providers of Distinction" program is simple to use and rewards you for participating! Visit **carecompass.ct.gov/providersofdistinction** to search by procedure or provider, or call 833-740-3258 to speak with a personal Care Coordinator.

Healthy Living Programs

Manage, or Reverse Diabetes

Get support managing Type 1 or Type 2 diabetes with Virta Health. You'll get a personal health coach, free testing supplies, and tips to manage your A1c. If you have Type 2 diabetes, you may qualify for Virta's reversal program, which offers personalized nutrition plans, support from medical providers and coaches, and digital tools to help you improve your health through lifestyle changes.

Prevent Diabetes

If you have prediabetes, the digital Diabetes Prevention Program offered by Wellspark can help you prevent diabetes by focusing on lifestyle changes.

Learn more: carecompass.ct.gov/diabetes

Health Enhancement Program (HEP)

The Health Enhancement Program (HEP) encourages you to take an active role in your health by getting age-appropriate wellness exams and screenings. **Retirees in Groups 4-9, and their enrolled dependents, are eligible for the Health Enhancement Program (HEP). The retirement dates for those groups are:**

- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017-July 1, 2022 (25 or more years of service OR hazardous duty)
- **Group 6:** Retirement date October 2, 2017 – July 1, 2022 (fewer than 25 years of service OR non-hazardous duty)
- **Group 7: Senior Judges and Trial Referees, (Not Included in Retiree Benefits, See Active Employee Benefits)**
- **Group 8:** Retirement date August 1, 2022 or later (Hazardous Duty)
- **Group 9:** Retirement date August 1, 2022 or later (Non- Hazardous Duty)

If you're a HEP participant and complete the HEP requirements as indicated in the table on **page 22**, you'll qualify for lower monthly premiums and reduced copays. You also won't pay a deductible when you receive in-network care. It's your choice whether or not to participate in HEP, but there are many advantages to doing so.

How to Enroll

- **Current retirees:** Your current HEP election will continue into the new plan year. If you are enrolling in benefits for the first time, you will automatically be enrolled in HEP. If currently HEP compliant, you can opt-out using the CO-1316 form available at **carecompass.ct.gov/forms**.
- **New retirees:** If you are a new retiree who was enrolled in HEP as an active employee when you retired, you do not have to enroll in HEP; your current HEP enrollment will continue. If you're not currently enrolled in HEP and would like to enroll, you must complete the HEP enrollment form when you make your benefit elections. The HEP enrollment form (CO-1314) is available at **carecompass.ct.gov/forms** or by calling 860-702-3533. You will not have to meet HEP requirements until the first calendar year in which you are enrolled in coverage as of January 1. If you do not wish to participate in HEP, you can opt-out during Open Enrollment.

Save Big with HEP

When you and all your enrolled family members participate in HEP, you will pay lower monthly premiums and have no in-network deductible for the plan year. If you or an enrolled family member has a chronic condition and you complete the HEP requirements, you may receive a $100 incentive and save money on prescription drugs.

HEP Requirements

HEP enrollees and all family members must get age-appropriate wellness exams and early diagnosis screenings, such as colorectal cancer screenings, Pap tests, mammograms, and vision exams.

Visit the **HEP online portal at carecompass.quantum-health.com** to find out whether you have outstanding dental, medical or other requirements. HEP requirements must be completed by December 31. Those with chronic conditions can complete certain requirements online. If you have a question, contact Quantum, the administrator for HEP, at 833-740-3258.

Chronic Condition Requirements

You and/or your family members will be required to participate in a disease education and counseling program if you have:

- Diabetes (type 1 or 2)
- Asthma
- COPD
- Heart disease/heart failure
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)

You will receive free office visits and reduced pharmacy copays for treatments related to your condition. Your household must meet all preventive and chronic requirements to be compliant.

2025 HEP Required Exams and Screenings

<table>
<tr><th rowspan="2">PREVENTIVE SCREENINGS</th><th>Dependent Requirements</th><th colspan="5">Employee and Spouse Requirements</th></tr>
<tr><th>6-25 years</th><th>18-29 years</th><th>30-39 years</th><th>40-49 years</th><th>50-64 years</th><th>65+ years</th></tr>
<tr><td>Preventive Visit</td><td></td><td colspan="5">Every 2 years</td></tr>
<tr><td>Dental Cleaning</td><td>At least 1 per year</td><td colspan="5">At least 1 per year</td></tr>
<tr><td>Cholesterol Screening</td><td rowspan="4"></td><td colspan="5">Every 5 years (age 20+)</td></tr>
<tr><td>Breast Cancer Screening (for women)</td><td colspan="2">N/A</td><td colspan="3">Mammogram every 2 years to age 75</td></tr>
<tr><td>Cervical Cancer Screening (for women)</td><td>Pap every 3 years (age 21+)</td><td colspan="3">Pap only every 3 years or Pap/HPV combo every 5 years</td><td>N/A</td></tr>
<tr><td>Colorectal Cancer Screening</td><td colspan="2">N/A</td><td colspan="3">Colonoscopy every 10 years (45+), Cologuard screening every 3 years, or Annual FIT/FOBT to age 75</td></tr>
</table>

Prescription Drug Coverage

Your prescription drug coverage is administered by CVS Caremark. Prescription benefits are the same no matter which medical plan you choose.

What you pay depends on whether your prescription is a generic, a preferred brand-name (on the CVS Caremark formulary), or a non-preferred brand-name drug.

Here's what you'll pay for covered prescription drugs.

In-Network	Groups 1 & 2		Group 3	
	Acute and Maintenance Drugs (up to a 90-day supply)	Caremark Mail Order/ Maintenance Drug Network[1] (90-day supply)	Acute and Maintenance Drugs (up to a 90-day supply)	Caremark Mail Order/ Maintenance Drug Network[1] (90-day supply)
Tier 1: Preferred generic	$3 copay	$0 copay	$5 copay	$0 copay
Tier 2: Generic	$3 copay	$0 copay	$5 copay	$0 copay
Tier 3: Preferred brand	$6 copay	$0 copay	$10 copay	$0 copay
Tier 4: Non-preferred brand	$6 copay	$0 copay	$25 copay	$0 copay

In-Network	Group 4			Group 5-9[2]		
	Acute Drugs (up to a 90-day supply)	Maintenance Drugs (90-day supply)[3]	HEP Enrolled[4]	Acute Drugs (up to a 90-day supply)	Maintenance Drugs (90-day supply)[3]	HEP Enrolled[4]
Tier 1: Preferred generic	$5 copay	$5 copay	$0 copay	$5 copay	$5 copay	$0 copay
Tier 2: Generic	$5 copay	$5 copay	$0 copay	$10 copay	$10 copay	$0 copay
Tier 3: Preferred brand	$20 copay	$10 copay	$5 copay	$25 copay	$25 copay	$5 copay
Tier 4: Non-preferred brand	$35 copay	$25 copay	$12.50 copay	$40 copay	$40 copay	$12.50 copay

[1] You are not required to fill your maintenance drug prescription using the maintenance drug network or CVS Caremark Mail Order. However, if you do, you will get a 90-day supply of maintenance medication for a $0 copay.

[2] Retirees in Group 5-9 have a different CVS Caremark formulary (that is, the covered drug list) than retirees in the other groups. The CVS Caremark Standard Formulary is focused on clinically effective lower-cost alternatives to high-cost drugs.

[3] You are required to fill your maintenance drugs using the maintenance drug network or CVS Caremark Mail Order.

[4] Maintenance drugs to treat (1) asthma or COPD; (2) diabetes (type 1 or 2); (3) heart failure/heart disease; (4) hyperlipidemia (high cholesterol); or (5) hypertension (high blood pressure): You are required to fill your maintenance drugs using the maintenance drug network or CVS Caremark Mail Order.

Out-of-Network Prescription Drug Coverage

	All Retirement Groups
Tier 1: Preferred generic	20% of prescription cost
Tier 2: Generic	20% of prescription cost
Tier 3: Preferred brand	20% of prescription cost
Tier 4: Non-preferred brand	20% of prescription cost

Prescription Drug Tiers

A drug's tier placement is determined by CVS Caremark and is reviewed quarterly. If new generics have become available, new clinical studies have been released, or new brand name drugs have become available, the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

Prescription Drug Programs

Your prescription drug coverage has the following programs to encourage the use of safe, effective and less costly prescription drugs.

- **Mandatory generics:** If a generic version of a prescribed drug is available, it will be dispensed automatically. A note from your doctor saying "dispense as written" is not sufficient. Without an approved exception, choosing a brand-name drug means you'll pay the generic copay plus the cost difference between the brand and generic.

  Coverage Exception Request forms (**carecompass.ct.gov/forms**) must be submitted to, and approved by, CVS Caremark.

- **CVS Specialty pharmacy:** Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). Specialty pharmacies, including many in Connecticut, offer expert support and resources to meet your unique medication needs. To learn more or explore these options, call **(800) 237-2767**.

  Your out-of-pocket costs for specialty drugs will be reduced at $0 with automatic enrollment in the PrudentRx program.You can choose to opt out of this program by going to **carecompass.ct.gov/forms**.

  Go to **carecompass.ct.gov/state/pharmacy** to view the Specialty Drug list, or for more information.

Tips for Reducing Your Prescription Drug Costs

- **Compare and contrast prescription drug costs.** Contact CVS Caremark to find the tier of the prescription drugs you and your family members use. If you have any Tier 3 or Tier 4 drugs, consider speaking with your doctor about switching to a generic equivalent.
- **Use the Maintenance Drug Network or the Mail Service Pharmacy.** If you are taking a maintenance medication for a long-term condition, such as asthma, high blood pressure or high cholesterol, switch your prescription from a retail pharmacy to the Maintenance Drug Network or the Mail Service Pharmacy. Once you begin using the Mail Service Pharmacy, you can conveniently order refills by phone or online. Contact CVS Caremark for more information.

Dental Coverage

You'll pay for the cost of dental coverage through deductions from your monthly pension check. Your premium contribution depends on the dental plan you choose, your retirement date and the number of covered individuals. **See page 10** for premiums.

Closed to new enrollments; the Total Care DHMO Plan offers better coverage and lower costs

	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan
Primary Care Dentist	Required	Not Required	Not Required	Required
Referred from Primary Care Dentist	Required	Not Required	Not Required	Required
In- and Out-of-Network Coverage*	No	Yes	Yes	No
What you pay when you get care	Coinsurance	Coinsurance	Coinsurance	Copays

** When you visit an out-of-network dentist, you are responsible for all charges above the maximum allowable charge—the amount the plan would have paid if you had visited an in-network dentist.*

Before changing your dental plan, be sure your dentist is in-network for your selected plan by contacting Cigna or visiting **Carecompass.ct.gov**.

Consider the Total Care DHMO plan

For many members, the Total Care DMHO Plan offers the lowest cost for the dental services you'll need this year. The plan network continues to expand and may already include your dentist. Enhancements to the Total Care DMHO plan have eliminated the need for the previous Dental Care DMHO Plan, which is now closed to future enrollments.

Need help picking a plan?

Visit **carecompass.ct.gov/benefits-enrollment** to take the Dental Plan Quiz. After answering some simple questions, get recommendations for the plan that best fits your needs and budget.

Dental Coverage at a Glance

Here's what you'll pay for covered dental services, depending on the plan you elect.

Closed to new enrollments; the Total Care DHMO Plan offers better coverage and lower costs

	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan
Annual deductible	None	$0 in-network, $25 & $75 out-of-network	None	None
Annual maximum	None	$5,000; $2,500 out-of-network (excluding orthodontia)	None	None
Exams, cleanings and x-rays	You pay $0	You pay $0, deductible does not apply[1]	You pay $0	You pay $0
Periodontal maintenance[2]	You pay 15%	You pay $0 in-network and out-of-network[1]	You pay 20% in-network and out-of-network, $0 for HEP enrollees	Copay[3]
Periodontal root scaling and planing[2]	You pay 15%	You pay $0 in-network, 50% out-of-network	You pay 40% in-network, 50% out-of-network	Copay[3]
Other periodontal services	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 50% in-network and out-of-network	Copay[3]
Simple Restoration				
Fillings	You pay 15%	You pay 20% in-network, 30% out-of-network	You pay 20% in-network, 30% out-of-network	Copay[3]
Oral surgery	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 30% in-network, 50% out-of-network	Copay[3]
Major Restorations				
Crowns	You pay 30%	You pay 33% in-network, 50% out-of-network	You pay 33% in-network, 50% out-of-network	Copay[3]
Dentures, fixed bridges	You pay 45%	You pay 50% in-network and out-of-network	Not covered[4]	Copay[3]
Implants	You pay 45% (one per year)	You pay 50% in-network and out-of-network (up to $500)	Not covered[4]	Copay[3]
Orthodontia	45% (24 month course of treatment — lifetime maximum)	You pay 50% (plan pays maximum of $2,000, $1,000 out-of-network, per person per lifetime)[5]	Not covered[4]	Copay[3]

[1] In the Enhanced plan, use an in-network dentist to ensure your care is covered 100%; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.

[2] If you're enrolled in the Health Enhancement Program (HEP), frequency limits and cost share are applicable.

[3] Contact Cigna at 800-244-6224 for patient copay amounts.

[4] While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 13 for details).

[5] Benefits are prorated over the course of treatment.

Cigna's Virtual Care Program

Get care for urgent dental concerns like a toothache, chipped tooth, infection and other oral health issues when you can't get to your regular dentist. This program is available 24 hours a day, 7 days a week at **stateofct.cigna.com**.

Health Enhancement Program (HEP)

If you participate in HEP (see page 21), up to two dental cleanings per year are 100% covered.

If you are in the Enhanced plan, you must use an in-network dentist to get the full coverage. If you go out of network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge).

In Total Care DHMO and Dental Care DMHO (closed to new enrollments) plans, you must use an in-network dentist, or your exam won't be covered at all.

Dependent Dental

Eligible dependents can now remain enrolled in state-sponsored dental coverage through the end of the year in which they turn age 26. See **page 2** for more information.

Oral Health Integration Program

If you have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation) you can receive up to 100% cost reimbursement Cigna's Oral Health Integration Program (OHIP) is available in all dental plan options. Learn how it works and how it can help at **stateofct.cigna.com**.

Savings on Non-Covered Services

Many dentists in the Basic and Enhanced plan networks provide lower fees for non-covered services. These savings may apply even if you've hit your annual maximum or if services are limited by age, frequency, or other plan rules. To get the discount, visit an in-network dentist and confirm the procedure is on their fee schedule before treatment. You'll pay the negotiated fee directly to the dentist.

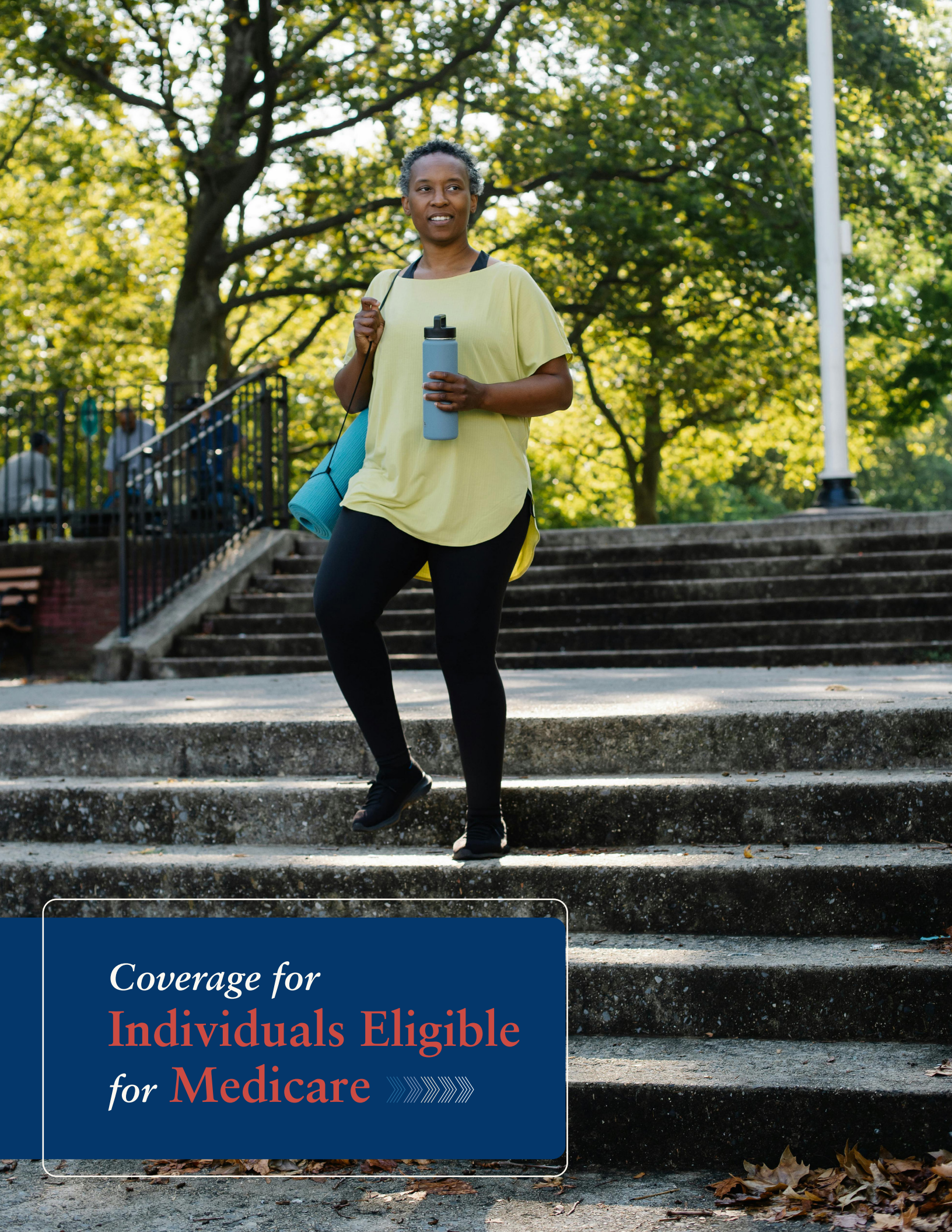
Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Be sure to check with your dental care professional, or contact Cigna customer service before receiving care to determine if these discounts will apply to you.

Pretreatment Estimates

Before starting any dental procedure that may cost more than $200, your dentist can submit a pretreatment estimate to the plan. You can also check your expected out-of-pocket costs for specific procedures by contacting Cigna at 800-244-6224 or visiting **carecompass.ct.gov/dental**.

Get the MyCigna mobile app

Download on the App Store | GET IT ON Google Play



Coverage for Individuals Eligible *for* Medicare

Medicare and You

As a Medicare-eligible retiree or dependent, you are eligible for medical, prescription drug and dental coverage under the State of Connecticut Retiree Health Plan.

Medicare-eligible coverage is only for Medicare-eligible retirees and their enrolled dependents who are also eligible for Medicare. If you or your dependents are NOT eligible for Medicare, please read **Coverage for Individuals NOT Eligible for Medicare**, which begins on **page 11**.

Medicare is a federal health care insurance program for people age 65 and older. The age at which you are eligible for Social Security may be higher than age 65, depending on the year in which you were born. While your Social Security retirement age may be higher than age 65, your eligibility for Medicare starts at age 65. Medicare enrollment is required for anyone who is eligible.

You May Be Missing Out on Additional Benefits

People younger than age 65 may also qualify for Medicare and Social Security Disability Insurance (SSDI) monthly cash benefits if the Social Security Administration finds that your health conditions meet their standard for disability. If you are eligible, these benefits may provide you with additional income from Social Security, as well as additional health care benefits available through Medicare, while continuing your benefits and maintaining your eligibility through the state. This offers additional benefits to you and provides a mutual benefit for the state.

The State of Connecticut has partnered with Public Consulting Group, Inc. (PCG), to assist our members with SSDI applications and Medicare enrollment, at no cost to our members. PCG combines a wealth of knowledge and expertise, with a hands-on, customer-focused approach, to help you file your SSDI application, and when successful, assist with early Medicare enrollment. PCG's staff will guide you step by step through the process. If you or a dependent is under age 65 and you/they feel you may be eligible for Social Security Disability Insurance, please call PCG at 800-805-8329. If you or a dependent is notified that you are eligible for Medicare, regardless of your/their age, contact the State of Connecticut Retiree Health Insurance Unit at 860-702-3533.

Medicare Part A and Part B

Medicare coverage has various parts. Medicare Part A (hospital care) is free, and enrollment is automatic if you are eligible for Medicare. You must enroll in Medicare Part B (physician services) and pay a monthly premium. It is essential that you enroll in Medicare Parts A and B for the first of the month you are first eligible for enrollment. Typically, this is the first of the month in which you turn 65. **We recommend that you contact Medicare to begin the enrollment process at least three months before your 65th birthday.** Failing to do so will result in a disruption in your health coverage.

Note: If you are not eligible for premium-free Medicare Part A, you are not required to enroll in Part A. If this is the case, you must submit a statement to the Retiree Health Insurance Unit from the Social Security Administration verifying that you are not eligible for premium-free Medicare Part A. You are still required to enroll in Medicare Part B, even if you are not eligible for Part A.

Once You Enroll in Medicare

As a State of Connecticut Retiree Health Plan member, when you reach age 65, the state will automatically enroll you in the Aetna Medicare Advantage PPO plan. Your state-sponsored medical and prescription coverage through the Aetna Medicare Advantage PPO plan will become your only medical and prescription plan.

Just before your 65th birthday, you will receive a letter from the Retiree Health Insurance Unit with more information about the Aetna Medicare Advantage PPO plan. Be sure to send the Retiree Health Insurance Unit a copy of your red, white and blue Medicare card. Your standard premium for Medicare Part B will be reimbursed by the state starting on the date a copy of your Medicare Part B card is received by the Retiree Health Insurance Unit. If cards are submitted more than 60 days past their issued date, reimbursement will be prospective from the date of receipt. Medicare premiums paid before a copy of your card is received will not be reimbursed. For 2025, the standard Medicare Part B/Part D premium reimbursement is **$185.00**.

You may be required to pay more than the standard premium or an income-related monthly adjustment amount (IRMAA) for Medicare Parts B and D in addition to the standard premium. Social Security will advise you by letter annually if you are required to pay a higher rate. **IMPORTANT:** To receive full reimbursement, send a copy of this letter, along with a copy of your red, white and blue Medicare card, to the Retiree Health Insurance Unit within 60 days of receipt. Information submitted more than 60 days past their issued date will be reimbursed prospective from the date of receipt. Retirees on or after August 1, 2022 are eligible for reimbursement of 50% of their Part B IRMAA in addition to the standard premium rate and their Part D IRMAA.

Note: If you lose eligibility for Medicare, you **MUST** contact the Retiree Health Insurance Unit right away to avoid a disruption in your coverage under the State of Connecticut Retiree Health Plan.

Avoid Disability-Related Penalties

If you or a dependent was eligible for Medicare at age 65 or earlier due to a disability, but you did not enroll in Medicare Part A and/or Part B, the Social Security Administration may assess a late enrollment penalty for each year in which you were eligible but failed to enroll. You will still be required to enroll in Medicare Part A and Part B in order to receive coverage through the State of Connecticut Retiree Health Plan, even if you are assessed a penalty.

Enrolling in Other Medicare Advantage or Medicare Prescription Drug Plans

The Aetna Medicare Advantage plan includes prescription drug coverage. When you or your enrolled dependents become eligible for Medicare, you will automatically be enrolled in the Aetna Medicare Advantage plan. You do not need to do anything except start using your Aetna card once you receive it. Once enrolled, you will receive more information. However, there are four key things to know:

The Aetna Medicare Advantage plan is your only option for state-sponsored medical and prescription drug coverage. If you opt out of the Aetna plan, you opt out of your state-sponsored coverage. Aetna is required by Medicare to inform you of the chance to opt out or cancel your enrollment. However, if you opt out, medical and prescription drug coverage and Medicare premium reimbursements for you and your dependents will terminate. **If you wish to continue state-sponsored health coverage, please ignore the opt-out information.**

Do not enroll in a stand-alone Medicare Advantage or Medicare prescription drug plan (Medicare Part C or Part D). You are only able to enroll in one Medicare Advantage and one Medicare Part D plan at a time. The Aetna Medicare Advantage plan includes Medicare Part D prescription drug coverage. **Enrolling in any other Medicare Advantage or Medicare Part D plan will disenroll you from the Aetna Medicare Advantage plan and cause your state-sponsored medical and pharmacy coverage to end for you and your dependents.**

Make sure we have your street address. If you receive your mail at a post office box, you must provide a residential street address to the Retiree Health Insurance Unit. This is a requirement of the U.S. Centers for Medicare & Medicaid Services. All communication will still go to your noted mailing address.

Promptly submit higher premium notices. If your premium will be more than the standard premium rate, send a copy of your IRMAA notice to the Retiree Health Insurance Unit to ensure proper reimbursement.

Individuals Who Are Not Eligible for Medicare

If you or your covered dependents are not yet eligible for Medicare (typically those under age 65), current medical coverage elections and prescription drug coverage through CVS Caremark will stay the same. There will be no change to the copay structure, and you/they will continue to participate in the current drug programs. For more information on non-Medicare-eligible coverage, **see page 11**.

Medical Coverage

Your medical coverage option is the Aetna Medicare Advantage PPO plan. Medicare Advantage plans (also known as Medicare Part C) combine all the benefits of Medicare Part A (hospital coverage) and Medicare Part B (medical coverage) into one plan and can also be combined with Medicare Part D (prescription drug coverage) to become one comprehensive hospital, medical and prescription drug plan. Medicare Advantage plans are offered by private insurance companies like Aetna.

Your medical coverage option is a group Medicare Advantage plan, which means it was created just for the State of Connecticut Retiree Health Plan. Unlike other Medicare Advantage plans you may see advertised elsewhere, you can only enroll in this plan through the State of Connecticut Retiree Health Plan.

How the Plan Works

The Aetna Medicare Advantage plan is a preferred provider organization (PPO) plan. Here are some highlights of the plan:

- You can see any doctor, hospital or other health care provider you choose, as long as they accept Medicare.
- You pay the same amount for care whether you see a network or non-network provider anywhere in the U.S.
- Medicare sees each enrolled member as an individual; you will have your own Medicare ID card and enrollment record.
- Your health care bills go to Aetna directly, **NOT** to Medicare. Then, your Aetna plan pays for your care. This is why it is very important for you to use your Aetna plan member ID card when you need health care services.

Please refer to the Aetna Medicare Advantage PPO plan Summary of Benefits or Evidence of Coverage for additional information about the medical plan.

Medical Coverage at a Glance

The table below shows the coverage available under the medical plan. As a reminder, the retirement groups are:

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 - July 2022 (Hazard Duty or more than 25 years)
- **Group 6:** Retirement date October 2, 2017 – July 1, 2022 (fewer than 25 years of service OR non-hazardous duty)
- **Group 8:** Retirement date August 1, 2022 or later (Hazardous Duty)
- **Group 9:** Retirement date August 1, 2022 or later (Non- Hazardous Duty)

Benefit Features	Aetna Medicare Advantage PPO Plan In-Network and Out-of-Network				
	Group 1	Group 2	Group 3	Group 4	Group 5-9
Annual deductible	None	None	None	None	None
Annual medical out-of-pocket maximum	$2,000	$2,000	$2,000	$2,000	$2,000
Primary care physician office visit	$5	$15	$15	$15	$15
Specialist office visit	$5	$15	$15	$15	$15
Preventive services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Emergency care	Plan pays 100%	Plan pays 100%	Plan pays 100%	$35	$125
Diagnostic radiology services (e.g., MRIs, CT scans)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Lab services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient x-rays	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient hospital care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Skilled nursing facility (SNF)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient surgery	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient rehabilitation (physical, occupational or speech/language therapy)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Therapeutic radiology services (such as radiation treatment for cancer)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%

Benefit Features	Aetna Medicare Advantage PPO Plan In-Network and Out-of-Network				
	Group 1	Group 2	Group 3	Group 4	Group 5-9
Ambulance	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Diabetes monitoring supplies	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Urgently needed services	$5	$15	$15	$15	$15
Routine physical (1 per plan year)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Acupuncture[1] (up to 20 visits per plan year)	$15	$15	$15	$15	$15
Chiropractic care[1] (unlimited visits per plan year)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Routine foot care[1] (6 visits per plan year)	$5	$15	$15	$15	$15
Routine hearing exam[1] (1 exam every 12 months)	$15	$15	$15	$15	$15
Hearing aids[1] (1 set within a 36-month period)	Unlimited allowance toward 2 hearing aids[2]	Unlimited allowance toward 2 hearing aids[2]	Unlimited allowance toward 2 hearing aids[2]	Unlimited allowance toward 2 hearing aids[2]	Unlimited allowance toward 2 hearing aids[2]
Routine vision exam[1] (1 exam every 12 months)	$15	$15	$15	$15	$15
Routine naturopathic services (unlimited visits)	$5	$15	$15	$15	$15

[1] *Benefits are combined in- and out-of-network.*

[2] *Plan pays 100% when a network hearing aid provider is used.*

Aetna Additional Programs

- **Healthy Home Visit**: Have a licensed doctor or nurse come to your home to review your health needs and do a home safety assessment.
- **24-hour nurse line**: Speak with a registered nurse, day or night, to get help with your health concerns.
- **Healthy Rewards Program**: Get gift cards when you complete important health care activities.
- **Telehealth**: Access care from the comfort of your own home.
- **SilverSneakers®**: Join any of several thousand participating locations nationwide or take online classes at home.
- **Nonemergency transportation**: Access nonemergency transportation to your medical appointments, up to 24 trips per year.
- **Resources For Living®**: Get referrals to services in your area.
- **Chronic health condition**: Support for members with multiple health conditions.
- **Readmission Avoidance Program**: Additional follow-up care and support following an inpatient stay.
- **Meal home delivery program:** You can get healthy, precooked meals delivered to your home after an inpatient hospital stay — at no extra cost.
- **Aetna Compassionate Care Program™**: Support for members, their families, and caregivers during difficult and sensitive times.
- **Healthy Aging Support program**: Support for members who are at an increasing risk for complications due to their chronic conditions.

Find more information about these benefits and more at **CT.AetnaMedicare.com**

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Medicare rules don't allow earned rewards to be used for Medicare-covered goods or services, including medical or prescription drug out-of-pocket costs. Earned rewards may not be used to pay for medical copays, prescription costs, or any other Medicare covered good or services. Earned rewards may also not be used on alcohol, tobacco or firearms or be converted to cash.

Rewards earned may be considered taxable income. Please consult your tax adviser if you have any questions regarding the taxability of rewards.

Qualifying participants who are eligible to perform the program activities may earn rewards by completing all or some of the program activities. Rewards will be distributed to participants in the form of a gift card. Rewards for 2025 cannot be earned after 12/31/2025, which is the expiration date of the program. Participants should check the terms of their Evidence of Coverage (EOC) prior to participating in any program activities. Except as set forth in the EOC, Aetna shall not be responsible for any costs associated with, or arising from, a participant's performance of program activities. Your participation in the Your Healthy Rewards program is voluntary and does not affect your benefits from your Aetna health plan. Eligibility is limited to the Aetna member that this communication was addressed to. Subject to benefits and eligibility verification.

Prescription Drug Coverage

Aetna contracts with Medicare, provides insurance and pays the claims for your pharmacy benefits. The plan has a tiered copay structure. This means the amount you pay for each prescription drug depends on whether your prescription is for a preferred generic drug, a generic drug, a brand name drug listed on Aetna's preferred drug list (the formulary), a non-preferred brand name drug or a specialty drug.

The amount you pay also depends on where you fill your medication and when you retired.

For questions about your prescription drug coverage, contact Aetna using the contact information on **page 44**.

Prescription Drug Coverage at a Glance

	Network Retail and Mail Service Pharmacy				
	Group 1	Group 2	Group 3	Group 4	Group 5-9
1- to 84-day supply of non-maintenance drugs					
Tier 1: Preferred generic	$3 copay	$3 copay	$5 copay	$5 copay	$5 copay
Tier 2: Generic	$3 copay	$3 copay	$5 copay	$5 copay	$5 copay
Tier 3: Preferred brand	$6 copay	$6 copay	$10 copay	$20 copay	$25 copay
Tier 4: Non-preferred brand	$6 copay	$6 copay	$25 copay	$35 copay	$40 copay
Tier 5: Specialty	$6 copay	$6 copay	$25 copay	$35 copay	$40 copay
1- to 84-day supply of maintenance drugs[1]					
Tier 1: Preferred generic	$3 copay	$3 copay	$5 copay	$5/$0 copay[2]	$5/$0 copay[2]
Tier 2: Generic	$3 copay	$3 copay	$5 copay	$5/$0 copay[2]	$5/$0 copay[2]
Tier 3: Preferred brand	$6 copay	$6 copay	$10 copay	$10/$5 copay[2]	$25/$5 copay[2]
Tier 4: Non-preferred brand	$6 copay	$6 copay	$25 copay	$25/$12.50 copay[2]	$40/$12.50 copay[2]
Tier 5: Specialty	$6 copay	$6 copay	$25 copay	$25/$12.50 copay[2]	$40/$12.50 copay[2]
84- to 90-day supply of maintenance drugs at a Preferred Pharmacy [1]					
Tier 1: Preferred generic	$0 copay	$0 copay	$0 copay	$5/$0 copay[2]	$5/$0 copay[2]
Tier 2: Generic	$0 copay	$0 copay	$0 copay	$5/$0 copay[2]	$10/$0 copay[2]
Tier 3: Preferred brand	$0 copay	$0 copay	$0 copay	$10/$5 copay[2]	$25/$5 copay[2]
Tier 4: Non-preferred brand	$0 copay	$0 copay	$0 copay	$25/$12.50 copay[2]	$40/$12.50 copay[2]
Tier 5: Specialty	$0 copay	$0 copay	$0 copay	$25/$12.50 copay[2]	$40/$12.50 copay[2]

[1] *The State of Connecticut Retiree Health Plan includes additional coverage not provided under Medicare Part D. A list of additional covered drugs as well as a list of maintenance drugs can be found in Aetna's Additional Drug Coverage document.*

[2] *Plan includes reduced copays for medications to treat (1) asthma or COPD; (2) diabetes (type 1 or 2); (3) heart failure/heart disease; (4) hyperlipidemia (high cholesterol); and (5) hypertension (high blood pressure). See Aetna's Additional Drug Coverage document for a list of drugs with a reduced copay.*

Prescription Drug Tiers

A drug's tier placement is determined by Aetna. You can review the full formulary, additional drug lists, and specific drug costs online at **ct.aetnamedicare.com**.

Prior Authorization

Certain prescription drugs require prior authorization. If a drug you are taking requires prior authorization, you must have your prescribing doctor ask for coverage of the drug by calling Aetna Customer Service at 1-855-648-0391 (TTY: 711), Monday to Friday, 8 AM to 9 PM ET. If you continue to fill your prescriptions for the drug without getting prior authorization, the drug will not be covered, and you may have to pay the full retail price.

Tips for Reducing Your Prescription Drug Costs

- **Compare and contrast prescription drug costs.** Contact Aetna to find the tier of the prescription drugs you and your family members use. If you have any Tier 3 or Tier 4 drugs, consider speaking with your doctor about switching to a generic equivalent.
- **Use a Preferred Network Pharmacies or CVS Caremark® Mail Service Pharmacy.** For most drugs you take on a regular basis, you may pay less by using a preferred network pharmacy or the CVS Caremark Mail Service Pharmacy. You can conveniently order refills by phone or online. Contact Aetna for more information.

Dental Coverage

You'll pay for the cost of dental coverage through deductions from your monthly pension check. Your premium contribution depends on the dental plan you choose, your retirement date and the number of covered individuals. **See page 10** for premiums.

Cigna is the administrator for all State of Connecticut dental plans.

Closed to new enrollments; the Total Care DHMO Plan offers better coverage and lower costs

	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan
Primary Care Dentist	Required	Not Required	Not Required	Required
Referred from Primary Care Dentist	Required	Not Required	Not Required	Required
In- and Out-of-Network Coverage*	No	Yes	Yes	No
What you pay when you get care	Coinsurance	Coinsurance	Coinsurance	Copays

* **Out-of-network coverage for the Basic and Enhanced plans has decreased for many dental procedures. When you visit an out-of-network dentist, you are responsible for all charges above the maximum allowable charge—the amount the plan would have paid if you had visited an in-network dentist.**

Consider the Total Care DHMO plan

For many members, the Total Care DMHO Plan offers the lowest cost for the dental services you'll need this year. The plan network continues to expand and may already include your dentist. Enhancements to the Total Care DMHO plan have eliminated the need for the previous Dental Care DMHO Plan, which is now closed to future enrollments.

Dependent Dental

Eligible dependents can now remain enrolled in state-sponsored dental coverage through the end of the year in which they turn age 26. **See page 2** for more information.

Check if your dentist is in your network

Before changing your dental plan, be sure your dentist is in-network for your selected plan by contacting Cigna or visiting **carecompass.ct.gov**.

Need help picking a plan?
Try the Dental Plan Decision Tool

Scan or visit **carecompass.ct.gov/benefits-enrollment** **Plan Decision Tool** (under **Dental**).

Dental Coverage at a Glance

Here's what you'll pay for covered dental services, depending on the plan you elect.

Closed to new enrollments; the Total Care DHMO Plan offers better coverage and lower costs

	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan
Annual deductible	None	$0 in-network, $25 & $75 out-of-network	None	None
Annual maximum	None	$5,000; $2,500 out-of-network (excluding orthodontia)	None	None
Exams, cleanings and x-rays	You pay $0	You pay $0, deductible does not apply[1]	You pay $0	You pay $0
Periodontal maintenance[2]	You pay 15%	You pay $0 in-network and out-of-network[1]	You pay 20% in-network and out-of-network, $0 for HEP enrollees	Copay[3]
Periodontal root scaling and planing[2]	You pay 15%	You pay $0 in-network, 50% out-of-network	You pay 40% in-network, 50% out-of-network	Copay[3]
Other periodontal services	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 50% in-network and out-of-network	Copay[3]
Simple Restoration				
Fillings	You pay 15%	You pay 20% in-network, 30% out-of-network	You pay 20% in-network, 30% out-of-network	Copay[3]
Oral surgery	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 30% in-network, 50% out-of-network	Copay[3]
Major Restorations				
Crowns	You pay 30%	You pay 33% in-network, 50% out-of-network	You pay 33% in-network, 50% out-of-network	Copay[3]
Dentures, fixed bridges	You pay 45%	You pay 50% in-network and out-of-network	Not covered[4]	Copay[3]
Implants	You pay 45% (one per year)	You pay 50% in-network and out-of-network (up to $500)	Not covered[4]	Copay[3]
Orthodontia	45% (24 month course of treatment — lifetime maximum)	You pay 50% (plan pays maximum of $2,000, $1,000 out-of-network, per person per lifetime)[5]	Not covered[4]	Copay[3]

[1] In the Enhanced plan, use an in-network dentist to ensure your care is covered 100%; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.

[2] If you're enrolled in the Health Enhancement Program (HEP), frequency limits and cost share are applicable.

[3] Contact Cigna at 800-244-6224 for patient copay amounts.

[4] While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 13 for details).

[5] Benefits are prorated over the course of treatment.

Cigna's Virtual Care Program

Get care for urgent dental concerns like a toothache, chipped tooth, infection and other oral health issues when you can't get to your regular dentist. This program is available 24 hours a day, 7 days a week at **stateofct.cigna.com**.

Health Enhancement Program (HEP)

If you participate in HEP (**see page 21**), up to two dental cleanings per year are 100% covered.

If you are in the Enhanced plan, you must use an in-network dentist to get the full coverage. If you go out of network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge).

In Total Care DHMO and Dental Care DMHO (closed to new enrollments) plans, you must use an in-network dentist, or your exam won't be covered at all.

Oral Health Integration Program

If you have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation) you can receive up to 100% cost reimbursement Cigna's Oral Health Integration Program (OHIP) is available in all dental plan options. Learn how it works and how it can help at **stateofct.cigna.com**.

Savings on Non-Covered Services

Many dentists in the Basic and Enhanced plan networks provide lower fees for non-covered services. These savings may apply even if you've hit your annual maximum or if services are limited by age, frequency, or other plan rules. To get the discount, visit an in-network dentist and confirm the procedure is on their fee schedule before treatment. You'll pay the negotiated fee directly to the dentist.

Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Be sure to check with your dental care professional, or contact Cigna customer service before receiving care to determine if these discounts will apply to you.

Pretreatment Estimates

Before starting any dental procedure that may cost more than $200, your dentist can submit a pretreatment estimate to the plan. You can also check your expected out-of-pocket costs for specific procedures by contacting Cigna at 800-244-6224 or visiting **carecompass.ct.gov/dental**.

Get the MyCigna mobile app

Download on the App Store

GET IT ON Google Play

Frequently Asked Questions

- **Where can I get more details about what the state health insurance plan covers?**

  For detailed benefit descriptions and information about how to access plan services, contact Aetna at the phone number or website listed on page 44.

- **Do I need to enroll in Medicare?**

  Yes! When you become age 65 or first become eligible for Medicare, you must enroll in Medicare Parts A and B. You must pay or continue to pay your monthly Part B premium. If you stop paying your Part B monthly premium, you risk losing your State of Connecticut Retiree Health Plan medical and prescription drug coverage.

- **Do retirees still have Medicare?**

  Yes. With the Aetna Medicare Advantage plan, retirees will have all the rights and privileges of Original Medicare. Instead of the federal government administering retirees' Medicare Part A and Part B benefits as it does under Original Medicare, Aetna is the administrator through the Aetna Medicare Advantage plan.

- **Are Medicare-eligible retirees and their Medicare-eligible dependents covered under the same policy, like family coverage?**

  No. While the Medicare-eligible retiree and any Medicare-eligible dependents will be enrolled in the same Aetna Medicare Advantage plan, Medicare considers each person to be a separate member. As a result, each Medicare-eligible plan member will receive his or her own Aetna ID card. It also means that each Aetna plan member will receive his or her own set of plan documents.

- **Is the Aetna Medicare Advantage PPO plan nationwide?**

  Yes, this plan offers nationwide coverage.

- **Do I need to use my red, white and blue Medicare card?**

  No, you should use your Aetna Medicare Advantage ID card for all covered medical and prescription drug needs. Put your Original Medicare card somewhere for safekeeping. It is important that you use your Aetna ID card each time you receive medical services or fill a prescription.

- **How are claims processed?**

  Aetna pays all claims directly. By always showing your Aetna ID card, you ensure your claims are processed correctly, in a timely way and accurately.

- **Is the Aetna Medicare Advantage PPO plan a Medicare Advantage HMO plan with a limited network?**

  No. It is a national plan that allows you to see doctors and hospitals anywhere in the U.S. You are not limited to seeing providers only in Connecticut. The plan travels with you throughout the U.S. The service area is all counties in all 50 U.S. states, the District of Columbia and all U.S. territories.

- **What happens if I travel outside the U.S. and need medical coverage?**

  You will have worldwide coverage for emergency and urgently needed care. You may need to pay the entire claim when receiving care and then submit the claim to Aetna for reimbursement after returning to the U.S.

Glossary

- **Brand name drug.** FDA-approved prescription drugs marketed under a specific brand name by the manufacturer. The FDA is the U.S. Food and Drug Administration.
- **Coinsurance.** The percentage of the cost you pay when you receive certain eligible health care services. Generally, you start paying coinsurance after you meet your annual deductible (see *Deductible* below).
- **Copay.** The flat-dollar amount you pay when you receive certain covered health care services (or when you fill a drug prescription). Generally, you start paying copays after you meet your annual deductible (see *Deductible* below).
- **Deductible.** The amount you pay for covered medical services each plan year before the plan pays benefits. Once you've met the deductible, you share the cost of covered medical services with the plan through coinsurance or copays.
- **Dental health maintenance organization (DHMO).** Entity that provides dental services through a limited network of providers. DHMO plan participants only obtain services from network dentists and need a referral from a primary care dentist before seeing a specialist.
- **Dependent.** A family member who meets the eligibility criteria established by the State of Connecticut Retiree Health Plan for plan enrollment.
- **Effective date.** The calendar year your health care coverage begins. You are not covered until your effective date.
- **Formulary.** A comprehensive list of prescription drugs that are covered by a prescription drug plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective. Formularies are updated periodically.
- **Generic drug.** The FDA-approved therapeutic equivalent to a brand name prescription drug containing the same active ingredients and costing less than the brand name drug.
- **Health maintenance organization (HMO).** An entity that provides health services through a closed network of providers. Unlike PPOs, HMOs employ their own staff or contract with specific groups of providers. HMO participants typically need a referral from a primary care provider before seeing a specialist.
- **In-network.** Providers or facilities that contract with a health plan to provide services at prenegotiated fees. You usually pay less when using an in-network provider.
- **Open Enrollment.** A period of time when you can change your health benefit elections without a qualifying status change.
- **Out-of-area.** A location outside the geographic area covered by a health plan's network of providers.
- **Out-of-network.** Providers or facilities that are not in your health plan's provider network. Some plans do not cover out-of-network services. Others charge a higher coinsurance when you receive out-of-network care.
- **Out-of-pocket costs.** The amount you pay—including premiums, copays and deductibles—for your health care.
- **Out-of-pocket maximum.** The most you'll pay out-of-pocket each plan year. When you meet the out-of-pocket maximum, the plan will pay 100% of covered expenses for the rest of the plan year.
- **Preferred provider organization (PPO).** A network of providers that provide in-network services to plan enrollees at negotiated rates. Enrollees can receive covered services from out-of-network providers, though often at a higher cost.
- **Premium contribution.** The amount you must pay on a monthly basis toward the cost of health care. This is automatically withdrawn from your monthly pension check.
- **Primary care physician (PCP).** Doctor (or nurse practitioner) who coordinates all your medical care. HMOs require all plan participants to select a PCP.
- **Qualifying status change.** A life event that allows you to make a change in your benefit elections outside of Open Enrollment, as defined by the IRS. Qualifying changes include marriage, separation, divorce, birth or adoption of a child, death of a dependent, and obtaining or losing other health coverage.
- **Reasonable and customary (R&C).** The average fee charged by a particular type of health care practitioner within a geographic area. R&C is often used by medical plans as the most they will pay for a specific test or procedure. If the fees are higher than the approved amount and care is received from a non-network provider, the individual receiving the service is responsible for paying the difference.
- **Specialty drug.** Generally, high-cost drugs used to treat long-term or chronic conditions.

10 Things Retirees Should Know

The State of Connecticut Retiree Health Plan is your trusted resource for health benefits information. If you have questions about your benefits, contact the Retiree Health Insurance Unit at 860-702-3533, or visit **carecompass.ct.gov**.

The retiree health benefits structure is determined by the state. Eligibility for retiree health benefits is determined by your retirement date and your eligibility for Medicare.

If you're enrolled in the Aetna Medicare Advantage PPO plan, you do not need to use your red, white and blue Medicare card. You should use your Aetna Medicare Advantage ID card for all covered medical and prescription drug needs. Put your Original Medicare card somewhere for safekeeping. It is important that you use your Aetna ID card each time you receive medical services or fill a prescription.

Retirees and dependents may be enrolled in different plans, depending on Medicare eligibility. All state health plan members who are eligible for Medicare are enrolled in the Aetna Medicare Advantage PPO plan. State health plan retirees and dependents who are not eligible for Medicare can choose from a variety of plan options, which do not include the Aetna Medicare Advantage plan. This means that some retirees and dependents may be enrolled in different plans. This is often referred to as a "split family."

Retirees and dependents must enroll in Medicare Part A and Part B as soon as they're eligible. Retirees and dependents who are Medicare-eligible based on age or disability must enroll in Medicare Part A hospital insurance (which is premium-free) and Medicare Part B medical insurance (you pay the premiums).

Do not enroll in a stand-alone Medicare Part D prescription drug plan, and provide the Retiree Health Insurance Unit with your Medicare Beneficiary Identifier (MBI) upon enrollment. The Aetna Medicare Advantage PPO plan includes Medicare prescription drug coverage. If you enroll in a stand-alone Medicare Part D (Medicare prescription drug) plan, you may be disenrolled from this plan.

Medicare-eligible members must pay premiums to the federal government. You must continue to pay Medicare for your Part B and/or IRMAA related Part D premiums. Your standard premium for Medicare Part B is reimbursed by the state starting with the date your Medicare Part B card is received by the Retiree Health Insurance Unit. Cards and premium information submitted more than 60 days past their issued date will be reimbursed prospective from the date of receipt.

Premiums for coverage must be paid, if applicable. Premiums you must pay for non-Medicare-eligible health coverage or dental coverage will automatically be deducted from your monthly pension check. If your pension check is not enough to cover the premium amount, you must pay the balance to continue eligibility for coverage.

You must disenroll ineligible dependents within 31 days after the date they become ineligible. Find more information on qualifying status changes on **page 6**. If you continue to cover an ineligible dependent after the 31-day period, you may be charged a fine.

If you change your home address, contact the Office of the State Comptroller. If you move, make sure to notify the Office of the State Comptroller about your change of address, so we can keep you informed about your benefits.

Contact Information

Coverage	Provider	Phone	Website
Questions about eligibility, enrollment, coverage changes and premiums	Office of the State Comptroller Retiree Health Insurance Unit	860-702-3533	**Carecompass.ct.gov**
Coverage for Non-Medicare-Eligible Individuals			
General benefit questions, Medical, and Health Enhancement Program (HEP)	Quantum Health	833-740-3258	**Carecompass.ct.gov** Or login to your benefits portal from Care Compass
Prescription drugs	CVS Caremark	800-318-2572	**Carecompass.ct.gov/state/pharmacy** Or connect to your CVS pharmacy account from your benefits portal: Login, then select, "My Plan", then "Pharmacy".
Dental	Cigna	800-244-6224	**Carecompass.ct.gov/state/dental** Or connect to your Cigna dental account from your benefits portal: Login, then select, "My Plan", then "Dental".
Coverage for Medicare-Eligible Individuals			
Medical and prescription drugs	Aetna	1-855-648-0391 (TTY: 711), Monday to Friday, 8 AM to 9 PM ET.	**ct.aetnamedicare.com**
Dental	Cigna	800-244-6224	**Carecompass.ct.gov/retireedental**

RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744-OE REV.4/2025

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
165 Capitol Ave.
Hartford, CT 06106-1775
www.osc.ct.gov

For Open Enrollment Use Only

Type or print and forward to the Retirement Health Insurance Unit.
Please refer to carecompass.ct.gov for your annual Health Care Options Planner for more information.

① Your Personal Information

Retiree/Survivor Last Name	**First Name, MI**	**Retirement Date**	**Employee Number** (From Active Employment)

Street Address (no P.O. boxes)	**City**	**State**	**Zip Code**

Social Security Number	**Date of Birth** (MM/DD/YYYY)	**Gender**	**Home Telephone Number**

Email Address	**Cell/Mobile Telephone Number**

② Application Type

	Enrollment Change: Select which changes you are making
☒ Annual Open Enrollment	☐ Medical Plan ☐ Dental Plan ☐ Dependent Change

③ Choose Non-Medicare Medical Plan

Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records.

- ☐ Primary Care Access [POE-G Plus]
- ☐ Standard Access [POE]
- ☐ Quality First Select Access [Prime Plus/Tiered POS] Only if Retiree's Permanent Residence is IN Connecticut
- ☐ Expanded Access [POS]
- ☐ Anthem State Preferred POS – **Currently Enrolled Only**
- ☐ Anthem Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**
- ☐ Waive Medical Coverage

④ Choose Your Dental Plan

☐ Basic Dental Plan ☐ Enhanced Dental Plan ☐ Total Care DHMO Plan ☐ Dental HMO Plan **Currently Enrolled Only** ☐ Waive Dental Coverage

⑤ Spouse/Dependent Information

List all of your dependents to be enrolled or dropped in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

Name	Relationship	Gender	Date of Birth	Social Security Number	Medical		Dental	
					Add	Drop	Add	Drop

⑥ Signature and Authorization

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services may be subject to exclusions, limitations, and conditions described by the health plan.
I certify that all information on this form is correct to the best of my knowledge and belief. I understand that providing false and/or incomplete information may result in the loss of coverage and/or nonpayment of claims for me or my eligible dependent(s). It is my responsibility to notify the Office of the State Comptroller when a dependent becomes ineligible. I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check and/or bill me as necessary for the medical and/or dental insurance indicated above.

Retiree/Survivor Signature	**Date**

Please complete this form and email to osc.rethealth@ct.gov

CO-744-OE HEALTH BENEFITS

Do NOT complete the application if you want to keep your current coverage without any changes. Your coverage will continue automatically.

Healthcare Policy & Benefit Services Division
Office of the State Comptroller
165 Capitol Avenue
Hartford, CT 06106

CARE COMPASS

carecompass.ct.gov

April 2025