2021 Anthem Spotlight FAQ's

Customer Support

(Hover over each logo for access to website)

Anthem Customer Support: 1.800.922.2232

HEALTH NAVIGATOR

1.866.611.8005

CARE COMPASS

CareCompass website has all the medical benefit information, including the Find-Care tool, Biweekly rates, plan comparisons, and other benefit links.

Contents

General Medical Benefits

Where can I find the name of the plan that I am currently in?
On your Anthem insurance card, the name of your plan is listed on the right side under State of Connecticut. It's also listed in the timecard system under Health Care Summary.

Where do I find my agency contact name or email?
Contact a Health Navigator at 1.866.611.8005.

Where can I find the benefit rates/costs for 2021?
All rates will be posted to our CareCompass site: https://carecompass.ct.gov

How can I review my current elections, providers, and costs and do a side-by-side comparison to other plans?
To view your current election costs, look at your paycheck. To view the 2021-2022 rates and plans, go to https://carecompass.ct.gov and look under medical for plan comparison, rate and use the Find-care tool to look up any providers.

Is there a fee if I request a duplicate ID card?
No fee. You can also use the Sydney App to access your card, email and or fax your card to a provider and view claims.

Do we have to wait exact one year for Annual physical? Last year (2020), I had physical on November 19th. Can I go for annual physical before November 19, 2021?
No, you do not have to wait a full year (365 days) for your next annual physical.

What happens when my in-network provider sends me to an in-network lab, but that lab referred me to another lab (that was out-of-network)? I got the full bill for "going to" an out-of-network provider. Can this charge be reversed?
Yes, if your "in-network" provider sends your lab samples to an out of network lab, you are not responsible for those charges. Please *contact Health Navigator for resolution at 1.866.611.8005***.**

If we switch from State BlueCare POE to State BlueCare POS will the deductible be adjusted for a partial year since the current plan year started in October instead of July?
The last plan year's deductible was extended to 15 months (July 1, 2019 - October 1, 2020). It was reset on 10/1 for a 9-month accumulation period which ends 6/30/21. Your deductible will reset on July 1, 2021 and this plan year will run through June 30, 2022.

How do I search for a Doctor on Anthem's Find Care site to know if they are in my plan network?

- Click on Find Care link
- Look under "How to avoid higher out of pocket costs".
- Click on the link for "Find State Preferred, Out of Area, State BlueCare POE Plus, POE and POS Preferred Primary Care Physicians or Specialists".
- Scroll down to search by plan; for example, "State BlueCare POE Plus, POE, POS". (There are also separate links to search for providers in the "State Preferred" and "Out of Area" plans).
- Insert your zip code when starting your online search.
- Click on the type of provider you are searching (Physicians, Hospital, Labs, Urgent Care, etc.)
- You can also call Anthem directly at 800-922-2232 for assistance with looking up providers.

Enrollment / Eligibility / Dependents

When does open enrollment start?
Open Enrollment is May 3 - May 28. Visit our Care Compass website for full details: https://carecompass.ct.gov/openenrollment/

If you don't want to make any changes to your current plans / selections, do you still need to re-enroll or fill out a form?
You do not. If you're happy with the coverage you currently have, you do not need to do anything. Your current coverage options and enrolled dependent coverage will continue.

Can insurance only be dropped during open enrollment?
You can only waive your insurance coverage during open enrollment which occurs one time per year; unless, you have a qualifying event, in which the event corresponds to your change (i.e., switching to a spouse's insurance).

I am expecting a baby soon, how to add the baby to the insurance?
Within 31 days after your baby's birth be sure to provide your agency HR/Payroll office with a copy of their birth certificate. They will provide you an enrollment form to complete in which you will add the baby to coverage.

I am getting married, how and when to I add my spouse to my plan?
The appropriate paperwork must be completed within 31 days of the date of event (marriage). Once all the appropriate documentation (marriage certificate) has been received a new spouse will become effective the first of the month following the date of the marriage.

My son will be 26 next month. Does Anthem remove him on his birthday? Do I need to file a change of family status to remove him from my coverage when that happens, or will it be automatic?
Medical and prescription drug coverage for dependent children is allowed until the end of the calendar year in which they turn 26, so he would be covered until December 31, 2021. Your agency HR/Payroll office will automatically remove him at the end of the calendar year and provide him with a COBRA notice.

My daughter is 23 and has a new job with medical benefits. is she required to take that coverage, or can she stay on my plan until she is 26?
She can stay on your plan until the end of the calendar year that she turns 26; however, she should check with her company before turning 26 to be sure she follows their qualifying event guidelines.

If family member(s) wants to be on their own insurance, can they drop off anytime or only during open enrollment?
A family member would need a qualifying event to be removed from coverage such as proof of enrollment in other coverage within 31 days of obtaining the new coverage.

I have my spouse and children on my coverage. When my children are removed due to the age restrictions, will my premium drop also?
Yes, your payroll deduction will automatically reduce to the Employee +1 rate for you and your spouse only.

Would I be able to add my significant other to my insurance through a "domestic partnership" qualification?
No. Domestic Partnership is not a qualifying relationship for health enrollment purposes.

If son moves out of my home, do I remove him from my insurance?
If your son is age 26 or younger, he may remain on your health coverage even if he is living elsewhere. If you choose to remove him from your coverage you may do so during Open Enrollment.

Can my spouse opt out of one medical option, like vision, but remain for everything?
No, employees and dependents can only be enrolled in the full medical coverage. They cannot remain enrolled in prescription coverage without being enrolled in medical coverage. They can opt out of dental at Open Enrollment or if they have a qualifying event.

My husband and I both work for State of CT and we are on the FLES plan, now if I want to change my plan, does my husband also have to change his plan?
The Family Less Employee Spouse (FLES) rate is available only when both spouses are enrolled in active coverage, eligible for health insurance, *and enrolled in the same* plan, along with at least one child. If you are enrolled in the FLES coverage level, both you and your spouse must enroll to participate in the Health Enhancement Program.

My husband is disabled and receives Medicare. What do I need to do to add him to my plan and keep his Medicare?
You may add your eligible spouse during the open enrollment period. While you are an active employee your Anthem coverage most likely will be the primary benefit; however, certain criteria are needed to confirm the primary coverage for your eligible spouse. If you have additional questions about coverage, please contact Health Navigator at 1.866.611.8005.

My son's coverage is through COBRA. Would he need to make the same choices using his separate account?
Yes, that's correct. He is now the lead subscriber for his own account. He will be able to change his coverage if he so chooses during Open Enrollment.

Is my son who is 21 years old and is disabled allowed on insurance?
If you have a dependent child covered under your current health plan through age 26, you will get a *Notice of Dependent Eligibility* letter and form from Anthem about 60 days before the date that your dependent child reaches the maximum age that he or she can be covered under your plan. The letter and form are for all child dependents, whether they are living with a disability or not. If your dependent child is disabled, check the box on the form that states this. Then, mail the form back to Anthem at: Anthem Blue Cross and Blue Shield; P.O. Box 1049; North Haven, CT 06473. You will receive the Certification for Mentally or Physically Handicapped Dependent Child beyond Maximum Age form. Please complete the form and return as directed. Anthem will review the information you provided and will notify you of the outcome.

Out of Area Plan Coverage / Travel Coverage

Does the POE "away from home care", cover care for college students out of state?
A participating provider is available in each of the 50 states and in Puerto Rico. Or, any member away from home for 90 consecutive days may enroll in the Away-From-Home Care program (AFHC). The AFHC will put your college student in touch with a local PCP to coordinate health care while away from home.

Which plan offers the most flexibility with choosing healthcare providers both in and out of state?

- State BlueCare POE, POE Plus and POS all use the same local provider network, State BlueCare.
- State BlueCare Prime Plus POS uses the State BlueCare Prime local network. For POE Plus and Prime POS Plus, your PCP must be CT-based, and you are required to get referrals to see specialists.
- All plans have National Access.

Which plan is available to me if I live out of the CT area?
If you are living in CT, RI or MA you may enroll in one of the State BlueCare plans. If you choose one of the gated plans your PCP must be CT-based. The PCP must be in Anthem's service area-this may include some providers in MA, RI or possibly NY that border CT. You should contact Anthem, 1-800-922-2232, to confirm your PCP participation status.

I am the benefit holder and I live in CT; however, my dependent lives out of state (and not in a bordering state to CT). Which plan is best for my family's needs?
If you are enrolled in a gated plan (State BlueCare Prime Plus POS or State BlueCare POE Plus) and your dependent is out of state for 90 consecutive days or more, it may be best for your dependent to enroll in the Away-From-Home Care (AFHC)program. The AFHC will put your dependent in touch with a local PCP to coordinate health care while away from home. If you are not in a gated plan like State BlueCare POE or State BlueCare POS, you have National Access and your dependent may locate participating providers in each of the 50 states and in Puerto Rico, or your dependent may choose to enroll in the AFHC program.

I plan to live out of state part-time this coming year (not for an extended time, but weekly alternating my location.) Is one plan better than the other for me?
All plans have National Access. You can locate a participating provider in each of the 50 states and in Puerto Rico. Please keep in mind, a gated plan (State BlueCare Prime Plus POS and State BlueCare POE Plus) requires referrals to see a specialist. Your PCP must be CT-based. Referrals are not required in the State BlueCare POS and State BlueCare POE plans.

Is national access an additional cost?
No.

Are we covered when traveling to the US and British Virgin Islands?
Yes.

Are there participating facilities or physicians overseas, for instance in Europe, Asia or Africa?
You have world-wide access and may find participating providers internationally. Please contact Anthem's dedicated customer service unit (800-922-2232) for additional information before international travel.

What if my child goes to college in Massachusetts?
Your coverage will follow them in Massachusetts. Additionally, Anthem has an Away-from-Home program that may be helpful for children living out of state.

If I travel out of the country and I need to see a doctor or go to the hospital. Would these visits be covered? If so, would I have to submit a claim, or would the provider have to call Anthem?
Medical emergencies are payable in or out of network. If you are in a participating facility while abroad, the participating facility will submit the claims on your behalf, and you will not need to pay out of pocket at the time of the medical episode. Otherwise, you will need to pay out of pocket and submit to Anthem for reimbursement.

I see HMO listed on my card and I've been trying to see a provider who is on the National Network, but they say they don't take it because it's an HMO.
Please contact our dedicated customer service for assistance (800-922-2232). Your provider needs to understand how the plan works. Most HMOs do not have National Access; however, you do through your State of CT Employee Health Plan benefits.

PCPs / Referrals / Labs / Copays / Deductibles

I live in a MA. Do I need to have a PCP in CT?
If you are enrolling in a gated plan, your PCP must be participating with the plan in which you are enrolled. The PCP must be in Anthem's service area-this may include some provider in MA, RI or possibly NY that border CT.

How does PCP send referral to see specialist?
It is an electronic process.

How long is a referral good for if you need one to see a specialist in one of the "plus" plans?
180 days

Do I need to get a referral for a specialist visit that I see regularly?
You would need a referral for different specialists, but once you have a referral for a specialist, you do not need to get one for any repeated visit within 180 days. The referral is valid for 180 days.

If there is a need to attend the emergency room, do we still need to pay the $250 copay?
Yes, the ER copay applies. If you are admitted to the hospital the co-pay is waived.

How do deductibles work? Do I pay for office visits until reach deductible threshold? Or do deductibles apply to hospital stay?
The deductible resets for each plan year, which runs July through June of each year. All out of network services, professional and hospital, combine to meet the deductible. Generally, you must pay all the costs from providers up to the deductible amount before your plan begins to pay.

With the family plan, does the $300 deductible for out of network with State BlueCare POS apply towards a single person using out of network care, or is it $900 total for the family before the 20% starts to kick in?
Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. Once you or a family member meet the individual deductible amount, the plan begins to pay for you or that family member. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

What's the preferred provider for lab work? LabCorp or Quest?
You can access the Care Compass website, go to Find Care link, scroll down to find preferred laboratory, x-ray or high-cost imaging providers. Employees must enter their desired zip code to see what labs are in your area. LabCorp and Quest are both options but may not be offered in all areas.

Do the labs that draw blood that are in network change throughout the year so I should check every time I go to the lab or if it the same for the entire year?
It is always best to confirm participation status. From CareCompass.ct.gov website, click on Find Care link, scroll down to find preferred laboratory, and insert your zip code to find an in-network lab close to you.

Plan Selection / Network Cost Comparison

What plans cover providers in Hartford Healthcare?
All the plans cover HHC except for Blue Care Prime POS Plus. If you are open to switching providers, you can save biweekly payment amounts and still have the same services covered.

How can I compare the plan coverage and costs?
Https://carecompass.ct.gov click on medical and look up the rates and plan comparisons. Every plan covers the same medical services, the differences lie in the network. To check to see if your providers are in network under the plan of your choice, use the Find-Care link

How do I know if my doctor, dentist, or medical group (i.e., UConn Health, St. Francis, etc.) are in network?

- **Medical**: Use Anthem's Find Care link to look up your doctors under your plan
- **Dental**: Use Cigna's Find a Dentist link to look up your dentist under your plan

How do I know if I have a Tier1 or Tier 2 provider? Why is Tier 1 considered better?
There is a zero-dollar copay for Value Tier 1 providers at a Value Tier 1 location. A $5.00 or $15.00 copay for all other PCP and specialists depending on your coverage. The employees can go to the care compass website to find a provider. The providers list will indicate if the physician is a Value Tier 1 at the location.

State Blue Care Prime Plus POS (The Newest Plan)

Does Hartford Health Care accept State BlueCare Prime Plus POS?
Hartford Healthcare has opted not to participate in the State BlueCare Prime Plus POS plan.

If we got approved for 'out of network override' in our current plan, will that carry over to our new plan?
It is best to contact Anthem to ensure the approval is "rolled over" to the new plan. This may not automatically occur as there would be a slight change in the ID # (prefix) and the group #.

If I went to Hartford Hospital for an ER visit and was admitted, does this mean my hospital, labs and doctors would not be covered?
If you are admitted the ER copay is a waived. ER admissions, in or out of network are paid at 100% per the State of CT Employee Health Plan. Covered ancillary services (lab, radiology, and inpatient doctor care) while admitted, are also paid at 100% per the State of CT Employee Health Plan.

Does the new State Blue Care Prime Plus POS plan require referrals to specialists?
Yes. In this plan, you are required to select an in-network CT-based primary care provider (PCP). This PCP will coordinate your care to ensure you receive the highest quality of care and remain in network to avoid out-of-network costs to you.

Under the State Blue Care Prime Plus POS plan, if I'm regularly seeing a specialist to manage a chronic illness, do I need a referral from my PCP each time I see that specialist or get a procedure ordered by that specialist?
Referrals are good for 180 days.

Under the State BlueCare Prime Plus POS, does a specialist referral mean you just need the Primary Care to send a referral to the specialist (a "doctor to doctor" referral, if you will), or does the Primary Care OR Specialist need to contact the insurance company for prior authorization/ an authorization number to see the specialist?
The referral process is all done electronically. A prior authorization is not required. It is more in line with the "doctor to doctor" scenario.

My Provider group has several MDs and an APRN, not all are on the list for the State Prime Blue Care Plus network, does that mean I can only be seen by the docs in the practice that are listed? What happens if the only ones that are available the day that I need help are the ones not in network?
Yes. Please ensure you are utilizing network providers to avoid any out-of-pocket costs.

State Blue Care POS

Does POS have a lifetime maximum?
No.

Does the POS still have Hartford Healthcare providers?
Yes.

Is POS the only plan that you can go to any doctor of your choice?
You may use an out of network provider in each of the POS plans (State BlueCare POS and State BlueCare Prime Plus POS), but you will incur greater out of pocket expenses.

Is telehealth covered out-of-network in the State BlueCare POS plan?
It is covered, but you will incur out of network cost shares. If the provider is out of network, the telehealth visit is out of network. The benefit is based on the provider's network status. To save costs, stay in-network.

Difference between POS and POE?
POE has in-network benefits only. If you go out of network your services will not be covered (except in the case of a medical emergency). In the POS plan you have in and out of network benefits. If you choose to go out-of-network, you will incur out of network cost shares and have greater out of pocket expense.

State Blue Care Plus POE

Does Blue Care Plus POE still have Hartford Health Care provider coverage?
Yes.

I live in Rhode Island and my PCP is in Wakefield, RI. How do these plans differences affect me? My current medical card says State BlueCare POE Plus HEP
The State BlueCare POE Plus plan requires you obtain referrals to see a specialist. You do not have out-of-network benefits.

I spend a lot of time in northern NY State, at Canadian border. How do I fulfill my HEP requirements /care with my State Blue Care Plus POE?
If you are out of state for 90 consecutive days or more, you may enroll in the Away-From-Home Care program. A local PCP will coordinate your care. If not, you have national access and will need to continue to obtain a referral from your designated PCP.

My son's PCP wants him to see a dermatologist and has given us a referral; do we need to contact the insurance company to get authorization to see the specialist too?
No, you will not need to contact Anthem to get authorization. Please ensure the PCP has referred you to an in-network specialist.

Vision / Massage Therapy /Chiropractor /Cosmetic Coverage

Is acupuncture covered at 20 visits per calendar year (Jan- Dec) or plan year (July 1, 2020- June 2021)?
Benefits are administered on a calendar year basis- January to December.

Can you see more than one chiropractor?
Yes, please see your in-network chiropractors on different days.

Is massage therapy covered?
No. There are discounts available through Special Offers. You must register at www.anthem.com/statect to access the Special Offers.

Is there coverage for eyeglasses?
The State of CT benefits does not cover eyeglasses or contacts, but an eye exam is covered. Discounts for frames, lenses or contacts are available through Special Offers. You must register at **www.anthem.com/statect** to access the Special Offers.

Is Lasik surgery covered?
Lasik surgery is not covered by the State of CT Employee health plan.

Is Cataract surgery covered?
Medically necessary surgery for the treatment of cataracts is covered.

Are sleep studies covered?
Yes, please use an in-network provider to avoid out of pocket costs.

Are smoking cessation programs covered?
Smoking cessation programs are not covered by your benefit plan. Please check online for Special Offers that may offer a discount on a smoking cessation program. You must register at **www.anthem.com/statect** to access the Special Offers.

Are visits to homeopathic/alternative medicine doctors covered?
Naturopathic doctors and acupuncturists are coverable providers. The services must also be covered by the health plan. Please check for an in-network provider to avoid additional out of pocket costs.

Could you provide instructions on how to access the eye accessory discount program?
Please begin at www.anthem.com/statect. You must register to access any discount programs available to you through Special Offers. Drag your cursor to "Care" and select discounts. Refine the results by selecting "vision, hearing and dental." Review the discounts available to you**.**

Are there any incentives for gym memberships?
There are no incentives for gym memberships. Please review the discount program available to you through Special Offers. You must register at www.anthem.com/statect to access the Special Offers**.**

Is there a discount for weight management programs?
Please review the discount program available to you through Special Offers. You must register at http://www.anthem.com/statect to access the Special Offers.

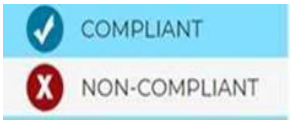
Do our medical benefits cover certain procedures that might be considered cosmetic depending on the circumstances?
Services considered cosmetic are not covered by the plan. Services must be deemed medically necessary. Please call Health Navigator (1.866.611.8005) for assistance with a specific condition or situation.

Health Enhancement Program (HEP) 2021

I am a new employee. How do I access the Health Enhancement Program?
You can access your Health Enhancement Requirements (HEP) at any time during a compliance year by logging on to CTHEP.com and register for your own personal account. If you prefer to speak to someone, you can call into our dedicate customer service line at 877-687-1448 M-Th 8-6 pm and Fr 8-5.

If my annual physical is in December and my provider can't see me the following year until January (13 months) am I out of compliance?
You do NOT have to wait 365 days to schedule a preventive visit. Your insurance pays for one every calendar year, regardless of when in the calendar year you have it.

How can we tell if we've met the HEP plan requirements?
When viewing your HEP portal, you can check on your individual compliance for the year as well as selecting the drop down to view your overall family compliance. If a service has been completed, you will have a green check mark and show Compliance. If the service is still Non-Compliant it will show a red x. See below:



Last year the requirement to meet HEP discounts were relaxed because of COVID, what will it be this year? After enrolling in a plan, how much time is allowed before meeting those requirements?
While HEP requirements were paused for 2020, they are active for 2021. You will have through December 31, 2021 to meet the necessary requirements. Telehealth visits may be applied. Visit ct.hep.com to see if you are missing any requirements.

HEP requirement for preventive visits every two years is confusing. My status for 2019 says 'not compliant', 2020 HEP was canceled and I didn't receive a letter saying I was out of compliance, so where can I tell if I am being penalized?
You can call into our customer service number at 877-687-1448 and the dedicated customer service associate can assist you and determine your compliance status. You can also view your paystub and check to see if there is a deduction for the standard plan.

Does the one per calendar year (for physicals) also applicable to mammograms (as age appropriate)?
The HEP requirements for age 50 and over are As Required by Physician. An employee can receive a mammogram every year.

Do you have to use HEP and are you penalized if you do not join it?
The Health Enhancement Program is a voluntary program offered to you by your employer, State of Connecticut. If you choose not to be a part of The Health Enhancement Program you would be placed in the standard plan and an additional $100 premium will be deducted from your insurance premium and an in-network deductible of $350 per individual, up to $1400 for family.

Do you automatically receive info about our annual physical for the HEP program or do we need to submit documentation?
As you obtain your required screenings, CMSI receives the claims data from your insurance carrier and uploads that data to your HEP portal. As the claims come in you will see your requirements marked as complete.

COVID Expenses

We were billed for a covid test my daughter had to get. Went to CVS they sent the test to someone not in network. We could not have known who they send the test to. Anthem paid $165 the bill was $200. They said we'd have to pay the remaining balance.
You are not responsible for any charges related to COVID testing or vaccination. Call Anthems dedicated customer service at 1.800-922-2232

Is the covid vaccine covered by insurance?
Yes, the vaccine is covered. There is no cost for the Covid vaccine.

Does anthem cover Covid testing if I'm out of the country and need to re-enter the USA, due to CDC guidelines requiring testing for anyone returning to the United States?
Yes, testing is covered when a member is re-entering the country after international travel. Your physician would order the medically necessary test.

How will the Anthem plans handle COVID related medical expenses? Will there be any benefit caps for these or special administration process (pre-authorization etc.)?
This question is very broad so we will need to provide a general response. Medically necessary treatment of COVID is payable. Prior authorization will need to be obtained for those services that require prior authorization, like for example, an inpatient stay. Please remember to use an in-network provider to avoid any out-of-pocket expenses when they would apply.

Regarding Covid testing at the airport, can we submit receipt and be reimbursed?
Medically necessary COVID tests are reimbursed per the participation status of the provider. If the provider is in-network, you will not have out of pocket expenses. If the provider is out-of-network, you may be balance billed.

If I need to get a second opinion on a health matter, is this additional appointment with another doctor covered?
Yes, you are responsible for the office visit copay. Be sure to use an in-network provider to avoid any additional out of pocket expenses.

My Sydney App

What is the logo for Sydney app?
Just go to your google play store or Apple store on your phone and look up 'My Sydney.'

What are the features of the My Sydney Mobil App?
Here are a few features: Access to benefits, member services, wellness resources, interactive chat, find a doctor, My-Health dashboard (a hub for personalized health and wellness), build a plan to meet your health goals, sync your fitness tracker and access your digital ID card or fax or email to your provider.

Do you have to create a portal for each person that is under your insurance?
Member's 16 and over, will need to create their own account if they desire to have access through the member portal. Parents can view claims of minor children (0 to 15 years)

Can we access a summary of visits and co-pays online or on the App and opt out of the mail statements from Anthem?

Yes, you may access visit and copay information online. You may also opt out paper statement by visiting the member preferences section on the member portal.