State of Connecticut

# 2021 Retiree Health Care Options Planner

# State of Connecticut Office of the Comptroller

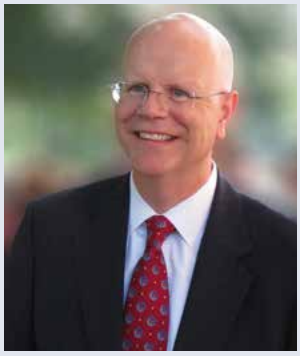
## Using Your Retiree Health Care Options Planner

This Planner is organized into coverage for non-Medicare-eligible individuals (starting on page 11) and coverage for Medicare-eligible individuals (starting on page 34). 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

When reviewing your coverage options, be sure you are reading the correct section (Medicare-eligible or non-Medicare-eligible), and then make sure you are looking at the benefits for the correct retirement group. While you may be eligible for Medicare, and therefore enrolled in the UnitedHealthcare Group 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.



**Kevin Lembo**
*State Comptroller*
*fb.com/ComptrollerKevinLembo*
*@ComptrolLembo*

**Welcome to Open Enrollment!**

Our daily choices affect our health and how much we pay out of pocket for health care. Even if you're happy with your current coverage, it's a good idea to review your health care options each year during Open Enrollment so you understand how your coverage works and whether you need to make any changes.

All of the State of Connecticut health care plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your and your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

During this Open Enrollment period, we encourage you to take a few minutes to consider your options and choose the plan that provides the best value for you and your family. Everyone wins when you make smart choices about your health care.

Kevin Lembo
State Comptroller

## COVID-19 Vaccination

You pay nothing ($0) for a COVID-19 vaccination. It's covered 100% by the state's plan. For eligibility information, visit **cdc.gov** or **ct.gov**.

## Want to learn more?

Join a Retiree Live Event:

- May 12: 4 – 5 pm
- May 20: 12:30 – 1:30 pm

Visit **CareCompass.CT.Gov/openenrollment** for meeting links and additional information.

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# Your 2021 Open Enrollment Checklist

Open Enrollment is **May 3** through **May 28, 2021** for benefits effective July 1, 2021. Complete this list before the May 28 deadline to get a better understanding of the 2021 changes and to make updates to your coverage.

- √ Read this Retiree Health Care Options Planner.
- √ Review the premium amounts for medical and dental coverage on page 10 (even if you are not making any changes to your coverage elections).
- √ Pay careful attention to the *What's New Starting July 1, 2021* section on page 2—it provides an overview of the 2021 changes to your health care coverage.
- √ If you decide to make changes, complete the Retiree Health Enrollment/ Change Form (CO-744-OE) on page 57 of this Planner. Be sure to:
  - Select the type of change you're requesting.
  - List all dependents you're covering and provide supporting documentation for new dependents.
  - Sign your application.
  - 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 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** or contact Health Navigator at 866-611-8005.

**Important!**

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).

# What's New Starting July 1, 2021

## All Retiree Coverage Changes

### Medical and Dental Plan Premiums

Premiums for the medical and dental plans are changing. You can find information about the new retiree premiums starting on page 9.

### Dental Plan Expansion

We're expanding our dental plan options to include a new Total Care DHMO plan. The Total Care DHMO covers exams and routine care, bridges, dentures, orthodontia, implants, periodontics, simple restoration (fillings), oral surgery and more! Plus, there's no annual deductible or calendar-year benefit maximum! See page 29 (non-Medicare-eligible) and 47 (Medicare-eligible) for more information about this new plan.

## Non-Medicare-Eligible Coverage Changes

### Upswing Health

Do you have pain keeping you up at night? Is a nagging injury slowing you down? Talk to a professional at Upswing Health for help with non-emergency orthopedic injury, including tendinitis, sprains, carpal tunnel syndrome, arthritis and more. Learn more on page 21.

# Recap of 2020 Changes

## All Retiree Coverage Changes

### Care Compass

Care Compass is a centralized hub dedicated to the state health insurance plan. It provides access to all health benefits materials and contact information at CareCompass.CT.Gov. Learn more on page 4.

## Non-Medicare-Eligible Coverage Changes

### Updated Medical Plan Options

Anthem became the only carrier administering our medical plans. With this change, we introduced the State BlueCare Prime Plus POS plan. Providers in this network commit to strict care experience and quality measures. By agreeing to see these high-quality providers, you get excellent care and pay lower premiums. Learn more about the State BlueCare Prime Plus POS plan on page 14.

### Health Navigator

The Health Navigator service—available by phone, web or online messenger chat—is here to help you navigate your state health plan benefits. Health Navigators can assist with finding Centers of Excellence, answering questions about benefits, and troubleshooting problems. The support you'll receive from Health Navigators will be highly coordinated with the member services teams at Anthem, Cigna, CVS Caremark and Care Management Solutions to make it easier for you to navigate your benefits and access the right care for you.

### Sydney Health Mobile App

Anthem's Sydney Health mobile app makes it easier to find out about your health benefits, look up claims status, access a digital ID card, or find an in-network doctor or care location.

### Network of Distinction

The State of Connecticut has identified some of the highest-quality doctors, hospitals and medical groups in the state for many common procedures. Doctors and care locations that have a proven track record for delivering high-quality, cost-effective care are designated a Network of Distinction under your health plan, and the highest-performing providers are designated as Centers of Excellence. Learn more on page 19.

# 2021 Open Enrollment Overview

**Open Enrollment: May 3 through May 28, 2021**

**Changes Effective: July 1, 2021 through June 30, 2022**

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.

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.

| 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… |
| • Anthem State BlueCare Prime Plus POS plan<br>• Anthem State BlueCare Point of Service (POS)<br>• Anthem State BlueCare Point of Enrollment (POE)<br>• Anthem State BlueCare Point of Enrollment Plus (POE-G)<br>• Anthem Out-of-Area (available only if retiree's permanent address is outside Connecticut)<br>• Anthem State Preferred Point of Service (POS)—closed to new enrollment | • Make a change to your medical coverage until the Medicare Open Enrollment period in October 2021. 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)<br>• Add or change your dental plan option<br>• Add or drop dependents from medical and dental coverage | • Add or change your dental plan option<br>• Add or drop dependents from medical and dental coverage |
| By submitting by May 28... | By submitting by May 28... |
| • A completed Retiree Health Enrollment/Change Form (CO-744-OE)<br>• Any required documentation supporting the addition of an eligible dependent | • A completed Retiree Health Enrollment/Change Form (CO-744-OE)<br>• 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 UnitedHealthcare Group 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 7 and 8.

# Using Your Benefits

## Care Compass

Care Compass is your one-stop shop for everything related to your state benefits! This centralized hub has all the information you need—including benefit charts, plan documents, carrier contact information, and more! Visit CareCompass.CT.Gov today.

## Health Navigator

If you're a pre-65 (non-Medicare-eligible) retiree or dependent, Health Navigator is here to take the confusion out of benefits. You and any enrolled dependents can contact Health Navigator for help understanding your benefits, finding a doctor, and dealing with the complexities of health care. The support you'll receive from Health Navigator will be highly coordinated with the member services teams at Anthem, Cigna, CVS Caremark and Care Management Solutions to make it easier for you to navigate your benefits and access the right care for you.

Health Navigator has an online search tool you can use to find the best quality providers and locations for a procedure. When you've found a location or provider, you can even call Health Navigator, and they'll make an appointment for you!

Chat with a professional Navigator 24/7 at 866-611-8005. Or use the convenient online chat tool at CareCompass.CT.Gov.

# Enrolling in Retiree Health Benefits

2021 Open Enrollment is May 3 through May 28, 2021, for coverage effective July 1, 2021 through June 30, 2022.

## Current Retirees

If you are a retiree, you and your dependents who are Medicare-eligible are enrolled automatically in the UnitedHealthcare Group Medicare Advantage (PPO) plan. You or your dependents do not need to complete an enrollment form unless changing dental coverage or changing your covered dependents.

If you want to make changes to your or your dependents' 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 57 of this Planner and return it to the Retiree Health Insurance Unit.

Questions about retiree health benefits? Call the Office of the State Comptroller, Retiree Health Insurance Unit at 860-702-3533, or email your question to **osc.rethealth@ct.gov**.

## 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 included in the back of this Planner.**
- 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.

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 enrolled automatically in the UnitedHealthcare Group 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."

## Waiving Coverage

If you have other medical coverage and want to waive State of Connecticut coverage when you're initially eligible, and you later lose your other coverage, you can enroll within 30 days of losing your other coverage, or during any Open Enrollment period. Retirees who do not want coverage 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 non-Medicare-eligible or Medicare-eligible retiree coverage, you **cannot** cover any dependents under the State of Connecticut Retiree Health Plan. You must be enrolled in order to cover your eligible dependents.

# 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 more about eligibility for retiree health benefits, contact the Retiree Health Insurance Unit at 860-702-3533.

## Dependent

It's important to understand who you can cover under the plan. It's critical that the state only provide coverage for eligible dependents. **If you enroll a person who is not eligible, you will have to pay federal and state taxes on the fair market value of benefits provided to that individual.**

Eligible dependents generally include:

- Your legally married spouse or civil union partner
- Eligible children, including natural and adopted children, stepchildren, and children residing with you for whom you are the legal guardian or under a court order, until the end of the year the child turns age 26 for medical coverage and until age 19 for dental coverage. Note: Children residing with you for whom you are the legal guardian or under a court order are eligible for coverage up to age 19, unless proof of continued dependency is provided.

Coverage eligibility for disabled children beyond age 26 for medical or age 19 for dental must be verified through Anthem. Contact their enhanced dedicated Member Services team at 800-922-2232 for details. 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 for medical coverage and 19th birthday for dental coverage. (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 becoming age 26 for medical coverage and age 19 for dental coverage. (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 for medical coverage and age 19 for dental coverage.
- 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.

Once enrolled, you must continuously enroll your disabled adult child in the State of Connecticut Retiree Health Plan and Medicare (if eligible) to maintain future eligibility.

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.

The Retiree Health Enrollment/Change Form (CO-744-OE) is available on page 57 of this Planner and online at CareCompass.CT.Gov.

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).

For information about documentation required for enrolling a new dependent or making changes to your coverage outside of Open Enrollment, see *Making Changes to Your Coverage During the Year* on page 7.

# Making Changes to Your Coverage During the Year

Once you choose your medical plan (if enrolled in non-Medicare-eligible coverage) and dental plan, you cannot make changes during the plan year unless you have a "qualifying status change," as defined by the IRS.

If you have a qualifying status change, you must notify the Retiree Health Insurance Unit **within 30 days after the event** and submit a Retiree Health Enrollment/Change Form (CO-744). If the required information is not received within 30 days, you must wait until the next Open Enrollment to make the change.

The change you make must be consistent with your change in status. Qualifying status changes and the documentation you must submit for each change are shown on the next page.

## 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 for health benefits, your surviving spouse must have been married to you at the time of your retirement and he/she 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 notify the Retiree Health Insurance Unit immediately. If you are legally separated or divorced, your spouse/former spouse is **not** eligible for coverage.

## 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<br>• Copy of a marriage certificate (issued in the U.S.)<br>• Birth certificate for any of your spouse's children you plan to cover<br>• A Social Security number for anyone you are adding to your coverage<br>• Proof of Medicare enrollment (if applicable) | First day of the month following the event date |
| Birth or adoption | • Completed enrollment application<br>• Copy of the birth certificate or adoption documentation | Newborn child: First of the month following the child's date of birth<br>Adopted child: The date the child is placed with you for adoption |
| Legal guardianship or court order | • Completed enrollment application<br>• Documentation of legal guardianship or court order | The first day of the month following the submission of proof of the event or court order |
| Divorce or legal separation | • Completed enrollment application<br>• Copy of the legal documentation of your family status change | Coverage will terminate on the first day of the month following the date in 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<br>• 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<br>• 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 CareCompass.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 page 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

If you have split family coverage—coverage where one or more members are eligible for Medicare and one or more members are not eligible for Medicare—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 they are enrolled in a plan that requires monthly premium contributions.

   Review the *Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage* section on page 10 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 will pay medical premium contributions only if you and your dependents are enrolled in a plan that requires monthly premium contributions.

Review the *Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage* section on page 10 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.

# Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage

| Coverage Level | Anthem State BlueCare Prime POS | Anthem State BlueCare POE-G | Anthem State BlueCare POE | Anthem State BlueCare 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** | $16.94 | $0 | $0 | $18.58 | $19.72 | $0 |
| **2 persons** | $37.27 | $0 | $0 | $40.88 | $43.39 | $0 |
| **3+ persons** | $45.74 | $0 | $0 | $50.17 | $53.26 | $0 |
| **Group 3: Retirement date 6/1/09 – 10/1/11** | | | | | | |
| **1 person** | $16.94 | $0 | $0 | $18.58 | $19.72 | $0 |
| **2 persons** | $37.27 | $0 | $0 | $40.88 | $43.39 | $0 |
| **3+ persons** | $45.74 | $0 | $0 | $50.17 | $53.26 | $0 |
| **Group 4: Retirement date 10/2/11 – 10/1/17** | | | | | | |
| **1 person** | $16.94 | $0 | $0 | $18.58 | $19.72 | $0 |
| **2 persons** | $37.27 | $0 | $0 | $40.88 | $43.39 | $0 |
| **3+ persons** | $45.74 | $0 | $0 | $50.17 | $53.26 | $0 |
| **Group 5: Retirement date 10/2/17 or later; 25 years of service or more OR hazardous duty** | | | | | | |
| **1 person** | $16.35 | $0 | $0 | $17.62 | $18.73 | $0 |
| **2 persons** | $35.97 | $0 | $0 | $38.76 | $41.21 | $0 |
| **3+ persons** | $44.14 | $0 | $0 | $47.56 | $50.57 | $0 |
| **Group 5: Retirement date 10/2/17 or later; fewer than 25 years of service OR non-hazardous duty** | | | | | | |
| **1 person** | $32.70 | $17.14 | $17.29 | $35.23 | $37.46 | $18.73 |
| **2 persons** | $71.94 | $37.70 | $38.04 | $77.51 | $82.41 | $41.21 |
| **3+ persons** | $88.28 | $46.27 | $46.68 | $95.13 | $101.14 | $50.57 |

** Closed to new enrollment*

**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 23 – 25.

**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.

# 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.

| Coverage Level | Basic Plan | Enhanced Plan | Cigna Dental Care DHMO Plan | Total Care DHMO Plan |
|---|---|---|---|---|
| **All Retirement Groups** | | | | |
| 1 person | $40.62 | $32.62 | $25.38 | $31.66 |
| 2 persons | $81.25 | $65.23 | $55.85 | $69.64 |
| 3+ persons | $81.25 | $65.23 | $68.54 | $85.47 |

# Coverage for Individuals Not Eligible for Medicare

**Non-Medicare-eligible coverage is only for non-Medicare-eligible retirees and non-Medicare-eligible dependents (of either non-Medicare-eligible or Medicare-eligible retirees).** If you are eligible for Medicare, please skip to *Coverage for Individuals Eligible for Medicare* which begins on page 34.

In general, the plans and coverage available to non-Medicare-eligible retirees and dependents are the same. However, certain copays and prescription drug programs vary based on your retirement date. Be sure to review the coverage for your retirement group.

# Medical Coverage

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

- Anthem State BlueCare Prime Plus (POS)
- Anthem State BlueCare Point of Enrollment Plus (POE-G)
- Anthem State BlueCare Point of Enrollment (POE)
- Anthem State BlueCare Point of Service (POS)
- Anthem State Preferred Point of Service (POS)—closed to new enrollment
- Anthem Out-of-Area (available only if retiree's permanent address is outside Connecticut)

When it comes to choosing a medical plan, there are six main areas to consider:

- **What is covered:** The services and supplies that are considered covered expenses under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies.
- **Cost:** What you pay when you receive medical care and what is deducted from your pension check for the cost of having coverage. What you pay at the time you receive services is similar across the plans. However, your premium share (that is, the amount you pay to have coverage) varies substantially, depending on the plan selected.
- **Networks:** Whether your doctor or hospital has contracted with Anthem to be a network provider. If your plan offers in- and out-of-network coverage, you'll pay less for most services when you receive them in-network. That's because in-network providers discount their fees, based on contractual arrangements they have with Anthem. If your plan does not offer in- and out-of-network coverage, you will not receive any benefits for services received outside the network (except in cases of emergency).
- **Quality doctors:** The state has identified which doctors provide the highest-quality care and outcomes in the state. While all plans provide access to these quality doctors, only one is devoted strictly to quality: the State BlueCare Prime Plus POS plan. This plan ensures that the only doctors included in its network are those that meet the highest quality standards. By agreeing to only go to the highest-quality doctors, you pay the lowest premiums of any plan option.
- **Plan features:** How you access care. Under some plans, you must use network providers (except in certain emergencies); others give you access to out-of-network providers. Plus, certain plans require you to have a primary care physician and receive referrals for in-network specialists.
- **Health promotion:** All the plans offer health information online; some offer additional services, such as 24-hour nurse advice lines and health risk assessment tools.

### The State BlueCare Prime Plus POS Plan

The State BlueCare Prime Plus POS plan offers an opportunity to save on premiums for using only the highest-quality doctors, specialists and locations across the state. The state has worked with Anthem to create a network of the highest-quality providers: the State BlueCare Prime Plus POS network. If you enroll in the State BlueCare Prime Plus POS plan, you must select a primary care physician (PCP) in the State BlueCare Prime Plus POS network and obtain a referral from your PCP for specialty care. Check **anthem.com/statect/find-care** to see if your current PCP or specialists are preferred providers with the plan. Services received without a referral or from an out-of-network provider are reimbursed at 70% of the allowable cost (after you pay the annual deductible).
Note: Hartford Health Care facilities and doctors are not currently participating in the State BlueCare Prime Plus POS network.

The table below helps you compare all your medical plan options based on the differences.

| | State BlueCare Prime Plus (POS) | Point of Enrollment Plus (POE-G) | Point of Enrollment (POE) | Point of Service (POS) | Out-of-Area |
|---|---|---|---|---|---|
| National network | X | X | X | X | X |
| Regional network | X | X | X | X | X |
| In- and out-of-network coverage available | X | | | X | X |
| In-network coverage only (except in emergencies) | | X | X | | |
| No referrals required for care from in-network providers | | | X | X | X |
| Primary care physician (PCP) coordinates all care | X | X | | | |

## 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 or later

# Anthem State BlueCare Prime Plus POS Plan: All Groups

| Benefit Features | In-Network with PCP Referral |
|---|---|
| **Annual deductible** | Individual: $350[1]<br>Family: $1,400[1] |
| **Annual medical out-of-pocket maximum** | Individual: $3,000<br>Family: $6,000 |
| **Preadmission authorization/concurrent review** | Through participating provider |
| **Primary care physician office visit** | Plan pays 100% |
| **Specialist office visit** | Plan pays 100% |
| **Preventive services** | Plan pays 100% |
| **Emergency care[2, 3]** | $250 |
| **Outpatient diagnostic imaging and lab[3]** | Value Tier 1 Provider: Plan pays 100%<br>Other Provider: 20% coinsurance, plan pays 80% |
| **Inpatient hospital care** | Plan pays 100% |
| **Skilled nursing facility (SNF)** | Plan pays 100% |
| **Outpatient surgery** | Plan pays 100% |
| **Short-term rehabilitation and physical therapy** | Plan pays 100% |
| **Preadmission testing** | Plan pays 100% |
| **Ambulance (if emergency)** | Plan pays 100% |
| **Inpatient mental health and substance abuse treatment** | Plan pays 100% |
| **Outpatient mental health and substance abuse treatment[3]** | Plan pays 100% |
| **Durable medical equipment[4]** | Plan pays 100% |
| **Prosthetics[4]** | Plan pays 100% |
| **Home health care (200 visits per year)** | Plan pays 100% |
| **Hospice** | Plan pays 100% |
| **Routine hearing exam (1 exam per year)** | $15 |
| **Hearing aids (1 set within a 36-month period)** | Plan pays 100% |

*[1] Waived for HEP-compliance members.*

*[2] Emergency room copay waived if admitted; waiver form available for certain circumstances: CareCompass.CT.Gov.*

*[3] No referral required.*

*[4] Prior authorization may be required.*

# Anthem State BlueCare Prime Plus POS Plan: All Groups

| Benefit Features | In-Network Without PCP Referral | Out-of-Network[1] |
|---|---|---|
| **Annual deductible** | Individual: $1,000<br>Family: $4,000 | |
| **Annual medical out-of-pocket maximum** | Individual: $5,000<br>Family: $10,000 | |
| **Preadmission authorization/ concurrent review** | Through participating provider | Through participating provider |
| **Primary care physician office visit** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Specialist office visit** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Preventive services** | Plan pays 100% | 30% coinsurance, plan pays 70% |
| **Emergency care[2, 3]** | $250 | $250 |
| **Outpatient diagnostic imaging and lab[3]** | Value Tier 1 Provider: Plan pays 100%<br>Other Provider: 20% coinsurance, plan pays 80% | 40% coinsurance, plan pays 60% |
| **Inpatient hospital care** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Skilled nursing facility (SNF)** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% (up to 60 days per year) |
| **Outpatient surgery** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Short-term rehabilitation and physical therapy** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Preadmission testing** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Ambulance (if emergency)** | Plan pays 100% | Plan pays 100% |
| **Inpatient mental health and substance abuse treatment** | Plan pays 100% | 30% coinsurance, plan pays 70% |
| **Outpatient mental health and substance abuse treatment[3]** | Plan pays 100% | 30% coinsurance, plan pays 70% |
| **Durable medical equipment[4]** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Prosthetics[4]** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Home health care (200 visits per year)** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Hospice** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |
| **Routine hearing exam (1 exam per year)** | $15 | $15 |
| **Hearing aids (1 set within a 36-month period)** | 30% coinsurance, plan pays 70% | 30% coinsurance, plan pays 70% |

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

*[2] Emergency room copay waived if admitted; waiver form available for certain circumstances: CareCompass.CT.Gov.*

*[3] No referral required.*

*[4] Prior authorization may be required.*

# Anthem POE-G, POE, POS and Out-of-Area Plans: In-Network

| Benefit Features | Group 1 | Group 2 | Group 3 | Group 4 | Group 5 |
|---|---|---|---|---|---|
| **Annual deductible** | None | None | None | Individual: $350[1]<br>Family: $350 per individual; $1,400 maximum per family[1] | Individual: $350[1]<br>Family: $350 per individual; $1,400 maximum per family[1] |
| **Annual medical out-of-pocket maximum** | Individual: $2,000<br>Family: $4,000 | Individual: $2,000<br>Family: $4,000 | Individual: $2,000<br>Family: $4,000 | Individual: $2,000<br>Family: $4,000 | Individual: $2,000<br>Family: $4,000 |
| **Preadmission authorization/ concurrent review** | Through participating provider | Through participating provider | Through participating provider | Through participating provider | Through participating provider |
| **Primary care physician office visit** | | | | | |
| **Tier 1 provider[2]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Tier 2 provider** | $5 | $15 | $15 | $15 | $15 |
| **Specialist office visit** | | | | | |
| **Tier 1 provider[2]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Tier 2 provider** | $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[3] | $250[3] |
| **Outpatient diagnostic imaging and lab** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Value Tier 1 Provider: Plan pays 100%<br>Other provider: 20% coinsurance, plan pays 80% |
| **Inpatient hospital care[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Skilled nursing facility (SNF)[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Outpatient surgery[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Short-term rehabilitation and physical therapy[5]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |

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

*[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.*

*[4] Prior authorization may be required.*

*[5] Subject to medical necessity review.*

| Benefit Features | Group 1 | Group 2 | Group 3 | Group 4 | Group 5 |
|---|---|---|---|---|---|
| **Preadmission testing** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Ambulance (if emergency)** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Inpatient mental health and substance abuse treatment[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Outpatient mental health and substance abuse treatment[4]** | $15 copay | $15 copay | $15 copay | $15 copay | $15 copay |
| **Durable medical equipment[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Prosthetics[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Home health care[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Hospice[4]** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Routine hearing exam (1 exam per year)** | $15 copay | $15 copay | $15 copay | $15 copay | $15 copay |
| **Hearing aids[4] (1 set within a 36-month period)** | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| **Routine vision exam (1 exam per year)** | $15 copay | $15 copay | $15 copay | $15 copay[6] | $15 copay[6] |

*[4] Prior authorization may be required.*

*[5] Subject to medical necessity review.*

*[6] HEP participants have $15 copay waived once every two years.*

# Anthem POS and Out-of-Area Plans: Out-of-Network

| Benefit Features | All Groups |
|---|---|
| **Annual deductible** | Individual: $300<br>Family: $300 per individual; $900 maximum per family |
| **Annual medical out-of-pocket maximum** | Individual: $2,300<br>Family: $4,900 |
| **Preadmission authorization/concurrent review** | Penalty of 20% up to $500 for no authorization |
| **Primary care physician office visit** | |
| **Tier 1 provider**[1] | 20% coinsurance, plan pays 80%[2] |
| **Tier 2 provider** | |
| **Specialist office visit** | |
| **Tier 1 provider**[1] | 20% coinsurance, plan pays 80%[2] |
| **Tier 2 provider** | |
| **Preventive services** | 20% coinsurance, plan pays 80%[2] |
| **Emergency care** | Same copay as in-network |
| **Outpatient diagnostic imaging and lab** | Groups 1 – 4: 20% coinsurance, plan pays 80%[2]<br>Group 5: 40% coinsurance, plan pays 60% |
| **Inpatient hospital care**[4] | 20% coinsurance, plan pays 80%[2] |
| **Skilled nursing facility (SNF)**[4] | 20% coinsurance, plan pays 80% (up to 60 days per year)[3] |
| **Outpatient surgery**[4] | 20% coinsurance, plan pays 80%[2] |
| **Short-term rehabilitation and physical therapy**[5] | 20% coinsurance, plan pays 80% (up to 60 inpatient days per condition per year; 30 outpatient days per condition per year)[2] |
| **Preadmission testing** | 20% coinsurance, plan pays 80%[2] |
| **Ambulance (if emergency)** | Plan pays 100% |
| **Inpatient mental health and substance abuse treatment**[4] | 20% coinsurance, plan pays 80%[2] |
| **Outpatient mental health and substance abuse treatment**[4] | 20% coinsurance, plan pays 80%[2] |
| **Durable medical equipment**[4] | 20% coinsurance, plan pays 80%[2] |
| **Prosthetics**[4] | 20% coinsurance, plan pays 80%[2] |
| **Home health care**[4] | 20% coinsurance, plan pays 80% (up to 200 visits per year)[2] |
| **Hospice**[4] | 20% coinsurance, plan pays 80% (up to 60 days per lifetime)[2] |
| **Routine hearing exam (1 exam per year)** | 20% coinsurance, plan pays 80%[2] |
| **Hearing aids**[4] **(1 set within a 36-month period)** | 20% coinsurance, plan pays 80% |
| **Routine vision exam (1 exam per year)** | 50% coinsurance, plan pays 50% |

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

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

*[3] 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).*

*[4] Emergency room copay waived if admitted; waiver form available for certain circumstances: CareCompass.CT.Gov.*

*[5] Prior authorization may be required.*

## Network of Distinction

Under this new program, we give you access to high-quality, cost-effective doctors and care locations that offer comprehensive care for many common medical tests and procedures, and health conditions. Those offering the highest quality will be noted as Centers of Excellence. The Network of Distinction can coordinate your care throughout your entire treatment process. This means your doctors are more informed to help you get the best care possible.

**Find a provider.** Use the online Health Navigator Search Tool to search by location, doctor and procedure. When you use the online tool, the providers and locations with the highest quality care standards have been designated as Centers of Excellence and will be listed first, indicated with a gold trophy. Other Network of Distinction options will follow, marked with a silver trophy. You can also call Health Navigator for assistance finding a Network of Distinction location or provider, or use the Find Care tool on **anthem.com/statect** or the Sydney mobile app.

**Earn incentives.** If you use a Network of Distinction provider for a qualifying procedure, you can earn a cash reward! When you use the best quality providers, you get the best care, and the state plan is more efficient because the risk of complications is reduced. If you visit a Center of Excellence, you can earn a greater incentive. Here's a list of some of the procedures eligible for a cash reward when performed by a Network of Distinction provider:

- Hip, shoulder and knee surgery
- Bariatric surgery
- Cardiac procedures
- Colonoscopies
- Prenatal care and delivery

Note: The amount of the reward varies by procedure and location. You can find more information by using the online Health Navigator Search Tool or by contacting Health Navigator.

**Travel reimbursement.** Depending on the distance traveled to obtain care from a Network of Distinction provider, you may be eligible for travel benefits. Contact Health Navigator to determine eligibility.

## Site of Service Providers

You pay nothing—$0 copay—for lab tests, x-rays and other imaging services (such as MRIs and CT scans) if you visit a preferred Site of Service provider. To find a Site of Service provider, contact Health Navigator, or use the Find Care tool on **anthem.com/statect** or the Sydney app.

> If you are not in Retirement Group 5, you do not have a special designation for outpatient lab tests and imaging. Coverage will be provided according to the table on pages 16 and 17.

## LiveHealth Online

LiveHealth Online connects you with a board-certified doctor for a video visit using your smartphone, tablet or computer. Doctors can answer your questions and assess illnesses such as sore throats, ear infections, pinkeye and the flu. They can even send a prescription to your pharmacy, if needed.

Get started by going to **livehealthonline.com** or downloading the free app. Spanish-speaking members can use Cuidado Médico through LiveHealth Online to schedule a video visit with a Spanish-speaking doctor, 7 a.m. – 11 p.m. ET, seven days a week. Registration is required. For preventive care and HEP chronic disease visits, a $0 copay applies. For sick and mental health visits, a $5 copay applies.

**Make an appointment for mental health-related concerns.**

LiveHealth Online therapists are available seven days a week to discuss anxiety, depression, stress, grief, eating disorders and other mental health concerns. Call 844-784-8409 to schedule an appointment.

## Medical Necessity Review for Therapy Services

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.

## Upswing Health

Upswing Health is your go-to for help with non-emergency orthopedic injury, including tendinitis, sprains, carpal tunnel syndrome, arthritis and more.

Use Upswing to:

- Learn about treating injuries at home (i.e., how to treat a sprained ankle, sudden back spasm, or a pulled muscle)
- Consult with a doctor over video or phone
- Get a custom, video-based rehab/exercise program emailed directly to you
- Expedite your care with a referral to a physician for in-person evaluation or testing, if needed
- Check on your progress and recovery

To get started, contact Upswing at 203-204-3855 or **info@upswinghealth.com**.
You can learn more about the program at **upswinghealth.com/CT**.

## Sydney Health Mobile App

With the Sydney Health app, you can find everything you need to know about your benefits in one place. Plus, you can now connect with Sydney Care℠ for a convenient way to get health answers and find affordable care when you need it. Services include:

- **Virtual visits**. Connect with a doctor who can help diagnose your condition, prescribe medications and recommend follow-up care. You'll pay nothing for a virtual (telehealth) preventive care visit with your doctor.
- **Verify coverage.** Use Sydney Health to check your benefits, review your claims and ID cards, and get fast answers using the interactive chat feature.
- **My Health Dashboard.** Complete the health assessment to get a personalized action plan based on your wellness priorities. Then, watch videos and read tips to live healthy, and find nutritionist-approved recipes and meal plans.
- **Symptom checker.** Not feeling well? See how others with similar symptoms were treated using an interactive chat. In just minutes you'll have reliable, personalized results.
- **Care Market.** Find and schedule in-person appointments with select Centers of Excellence and Network of Distinction care providers.

Download the Sydney Health app from the App Store® or Google Play™.

# Additional Programs

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

- **Health and wellness programs.** Anthem has a full range of wellness programs, online tools and resources designed to meet your needs. Wellness topics include weight loss, smoking cessation, diabetes control, autism education and assistance with managing eating disorders.
- **24/7 NurseLine.** The 24/7 NurseLine provides answers to health-related questions, provided by a registered nurse. You can talk to the nurse about your symptoms, medicines and side effects, and reliable self-care home treatments. To reach the NurseLine, call 800-711-5947.
- **Anthem Behavioral Health Care Manager.** Call an Anthem Behavioral Health Care Manager when you or a family member needs behavioral health care or substance abuse treatment: 888-605-0580. To see how to access care, visit **anthem.com/statect**.
- **BlueCard® and BlueCard Worldwide.** You have access to doctors and hospitals across the country with the BlueCard program. With the BlueCard Worldwide program, you have access to network providers in nearly 200 countries around the world. Call 800-810-BLUE (2583) to learn more.
- **Online access to network provider information, claims and cost-comparison tools.** Visit **anthem.com/statect** to find a doctor, check your claims and compare costs for care near you. If you haven't registered on the site, choose **Register Now** and follow the steps. Download the free mobile app by searching for "Anthem Blue Cross and Blue Shield" at the App Store or on Google Play. Use the app to show your ID card, get turn-by-turn directions to a doctor or urgent care, and more.
- **Special offers.** Go to **anthem.com/statect** to find special health-related discounts, including weight-loss programs, gym memberships, vitamins, glasses, contact lenses and more.

# 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 Group 4 and Group 5, 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 or later

If you're a HEP participant and complete the HEP requirements as indicated in the table on page 24, 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.

## Enrolling in HEP

### 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 (CO-1314) when you make your benefit elections. Enrollment forms are available from the Retiree Health Insurance Unit at cthep.com or by calling 860-702-3533. If you don't want to continue HEP participation, you can disenroll during Open Enrollment.

### Current Retirees

If you are a current retiree **not** participating in HEP, you can enroll during Open Enrollment. Enrollment forms are available from the Retiree Health Insurance Unit at cthep.com or by calling 860-702-3533.

### Continuing Your HEP Enrollment

If you participate in HEP and successfully meet all the annual HEP requirements, you will be re-enrolled automatically the following year and continue to pay lower premiums for health care coverage.

## 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 **cthep.com** to find out whether you have outstanding dental, medical or other requirements. If you have chronic conditions, you can complete requirements online. Contact Care Management Solutions, the HEP administrator, at 877-687-1448.

**HEP requirements must be completed by December 31.**

| Preventive Screenings | Age | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0 – 5 | 6 – 17 | 18 – 24 | 25 – 29 | 30 – 39 | 40 – 49 | 50+ |
| **Preventive doctor office visit** | 1 per year | 1 every other year | Every 3 years | Every 3 years | Every 3 years | Every 2 years | Every year |
| **Vision exam** | N/A | N/A | Every 7 years | Every 7 years | Every 7 years | Every 4 years | 50 – 64: Every 3 years<br>65+: Every 2 years |
| **Dental cleanings**[1] | N/A | At least 1 per year | At least 1 per year | At least 1 per year | At least 1 per year | At least 1 per year | At least 1 per year |
| **Cholesterol screening** | N/A | N/A | 20+: Every 5 years | Every 5 years | Every 5 years | Every 5 years | Every 5 years |
| **Breast cancer screening (mammogram)** | N/A | N/A | N/A | N/A | N/A | 1 screening between ages 45 and 49[2] | As recommended by physician |
| **Cervical cancer screening (Pap test)** | N/A | N/A | 21+: Every 3 years | Every 3 years | Every 3 years or Pap and HPV combo screening every 5 years | Every 3 years or Pap and HPV combo screening every 5 years | 50 – 65: Every 3 years or Pap and HPV combo screening every 5 years |
| **Colorectal cancer screening** | N/A | N/A | N/A | N/A | N/A | N/A | Colonoscopy every 10 years, annual FIT/FOBT to age 70 or Cologuard screening every 3 years |

*[1] Dental cleanings are required for family members who are participating in one of the state dental plans.*

*[2] Or as recommended by your physician.*



### Additional HEP Requirements for Those with Certain Chronic Conditions

If you or any of your enrolled family members have one of the following health conditions, you and/or that family member must participate in a disease education and counseling program to meet HEP requirements.

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

Doctor office visits will be at no cost to you, and your pharmacy copays will be reduced for treatment related to your condition. To receive HEP benefits, your household must meet all preventive and chronic care requirements.

You can also call Care Management Solutions to speak with a representative. See page 56 for contact information.

### Help to Manage Diabetes

Manage your diabetes with help from the Livongo diabetes management program. Monitor your conditions through digitally connected devices, receive health nudges, and access 24/7 digital and live coaching, all from your home, all at no cost through the state plan. Visit **join.livongo.com/CONNECTICUT** to learn more.

## More Information About HEP

Visit the HEP portal at **cthep.com** to find out whether you have outstanding dental, medical or other requirements to complete. If you or an enrolled dependent has a chronic condition, you/they can also complete chronic condition requirements online. Any medical decisions will continue to be made by you/your enrolled dependents and your/their physician.

Care Management Solutions, an affiliate of ConnectiCare, administers HEP. The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. You can visit **cthep.com** to:

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement(s)
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals

# Prescription Drug Coverage

No matter which medical plan you choose, your non-Medicare prescription drug coverage is provided through CVS Caremark. The plan has a four-tier copay structure. The amount you pay for prescription drugs depends on whether your prescription is for a preferred generic drug, a generic drug, a brand name drug listed on CVS Caremark's preferred drug list (the formulary), or a non-preferred brand name drug. The amount you pay also depends on where you fill your medication and when you retired, as shown in the following tables.

## In-Network Prescription Drug Coverage

| | Groups 1 and 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 |

| | Group 4 | | | Group 5[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 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.** Your prescription will be filled automatically with a generic drug if one is available, unless your doctor completes CVS Caremark's Coverage Exception Request Form, and the form is approved by CVS Caremark. **(It is not enough for your doctor to note "dispense as written" on your prescription; completion of the Coverage Exception Request Form is required.)**

  If you request a brand name drug instead of a generic alternative without obtaining a coverage exception, you will pay the generic drug copay **PLUS** the difference in cost between the brand and generic drug.

- **CVS Specialty Pharmacy.** Treatment of certain chronic and/or genetic conditions requires special pharmacy products, which are often injected or infused. The Specialty Pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 800-237-2767 for 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

Cigna is the dental carrier for the State of Connecticut's three dental plans:

- ***New!* Total Care DHMO Plan.** This plan provides dental services only from a defined network of dentists and pays benefits only when you receive care from a network dentist (except in cases of emergency). You must select a primary care dentist. He/she will coordinate your care. Referrals are required for all specialist services. There's no annual deductible or calendar-year maximum. When you need care, you pay coinsurance based on the service you receive.
- **Enhanced Plan.** This plan also allows you to visit any dentist or dental specialist without a referral, but pays a different level of benefits than the Basic Plan.
- **Cigna Dental Care DHMO Plan.** This plan provides dental services only from a defined network of dentists and pays benefits only when you receive care from a network dentist (except in cases of emergency). You must select a primary care dentist. He/she will coordinate your care. Referrals are required for all specialist services. There's no annual deductible or calendar-year maximum. When you need care, you pay copays based on the service you receive.
- **Basic Plan.** This plan allows you to visit any dentist or dental specialist without a referral.

> Many of the Basic and Enhanced Plan network dentists have agreed to offer their discounted fees to you and your enrolled dependents for non-covered services. You must visit network dentists to receive the discounts (savings will not apply for care received from non-participating dentists). Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment. You are responsible for paying the negotiated fees directly to the dentist.

### myCigna Mobile App

Download the myCigna mobile app on Google Play (Android) or the App Store (Apple) to get access to your personal information on the go. Through the app, you can find care and costs, view claims, update your personal information and more!

# Dental Coverage at a Glance

| | Total Care DHMO Plan | Enhanced Plan | Cigna Dental Care DHMO Plan | Basic Plan |
|---|---|---|---|---|
| **Annual deductible** | None | Individual: $25<br>Family: $75<br>The deductible does not apply to routine exams, cleanings and x-rays | None | None |
| **Annual benefit maximum** | None | $3,000 per person; excluding orthodontia | None | None |
| **Routine exams, cleanings, x-rays** | Plan pays 100% | Plan pays 100%[1] | Covered[3] | Plan pays 100% |
| **Periodontal maintenance[2]** | 15% coinsurance, plan pays 85% | Plan pays 100%[1] | Covered[3] | 20% coinsurance, plan pays 80% (if enrolled in HEP, covered at 100%) |
| **Periodontal root scaling and planing[2]** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[3] | 50% coinsurance, plan pays 50% |
| **Other periodontal services** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[3] | 50% coinsurance, plan pays 50% |
| **Simple restorations** | | | | |
| **Fillings** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[3] | 20% coinsurance, plan pays 80% |
| **Oral surgery** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[3] | 33% coinsurance, plan pays 67% |
| **Major restorations** | | | | |
| **Crowns** | 30% coinsurance, plan pays 70% | 33% coinsurance, plan pays 67% | Covered[3] | 33% coinsurance, plan pays 67% |
| **Dentures, fixed bridges** | 45% coinsurance, plan pays 55% | 50% coinsurance, plan pays 50% | Covered[3] | Not covered[4] |
| **Implants** | 45% coinsurance, plan pays 55% (one per year) | 50% coinsurance, plan pays 50% (maximum of $500) | Covered[3] | Not covered[4] |
| **Orthodontia** | 45% coinsurance, plan pays 55% | 50% coinsurance, plan pays a maximum of $1,500 per person per lifetime[5] | Covered[3] | Not covered[4] |

*[1] You must use an in-network dentist to receive 100% coverage; if you use an out-of-network dentist, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.*

*[2] If you are enrolled in the Health Enhancement Program, frequency limits and cost share are applicable.*

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

*[4] While these services are not covered, you will get the discounted rate on these services if you visit an in-network dentist, unless prohibited by state law.*

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

# Comparing Your Dental Coverage Options

| | Cigna Dental Care DHMO Plan and Total Care DHMO Plan | Enhanced Plan | Basic Plan |
|---|---|---|---|
| **Can I receive services from any dentist?** | No, all services must be received from a contracted in-network dentist | Yes, but you will pay less when you choose an in-network provider | Yes, but you will pay less when you choose an in-network provider |
| **Do I need a referral for specialty dental care?** | Yes | No | No |
| **Will I pay a flat rate for most services?** | Yes | No, you will pay a percentage of the cost of most services after you reach your annual deductible | No, you will pay a percentage of the cost of most services |
| **Must I live in a certain service area to enroll?** | Yes, you must live in the DHMO's service area | No | No |
| **Is orthodontia covered?** | Yes | Yes | No |
| **Are dentures or bridges covered?** | Yes | Yes | No |

**Need help choosing a dental plan?**

Try Cigna's decision support tool: zingtree.com/show/233326574000.

## Pretreatment Estimates

Before starting extensive dental procedures for which the dentist's charges may exceed $200, you can ask your dentist to submit a pretreatment estimate to the plan. You can also help to determine the amount you will be required to pay for a specific procedure by using the plan's website. More details about covered expenses are available by contacting Cigna at 800-244-6224 or cigna.com/stateofct.

## Cigna Dental Programs

- **Oral Health Integration Program®.** Enrolled retirees and dependents have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program (OHIP). With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services. Qualifying medical conditions for OHIP include heart disease, stroke, diabetes, pregnancy, chronic kidney disease, organ transplants, and head and neck cancer radiation. For additional information about OHIP, visit cigna.com/stateofct.
- **Healthy Rewards®.** Cigna's Healthy Rewards program provides discounts of up to 60% on health-related programs and services. There's no time limit or maximum for these instant savings when you visit a participating provider or shop online. No referrals or claim forms are needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins. Learn more about Healthy Rewards at cigna.com/rewards (password: savings) or by calling 800-258-3312.

### Consider the Cigna Dental Care DHMO Plan or the Total Care DHMO Plan

The DHMO network continues to grow! Did you know that many retirees enrolled in the Basic and Enhanced plans are already seeing DHMO providers? Be sure to check your provider's status at cigna.com/stateofct. Enrolling in the DHMO could help you save money.

# Frequently Asked Questions

## General

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

  All medical plans offered by the State of Connecticut cover the same services and supplies with the same copays. For detailed benefit descriptions and information about how to access state health insurance plan services, contact Anthem or visit CareCompass.CT.Gov.

- **Can I enroll later or switch plans midyear?**

  Generally, the elections you make at Open Enrollment are effective July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections midyear (see pages 7 and 8). If you decline coverage now, you can enroll during any future Open Enrollment or if you have certain qualifying status changes.

## Medical Coverage

- **I live outside Connecticut. Do I need to choose the Anthem Out-of-Area plan?**

  If your permanent address is outside Connecticut, we will place you automatically in the Anthem Out-of-Area plan, giving you access to a national network of providers. There are no retiree premium shares for enrollment in an Out-of-Area plan for those retired before October 2, 2017.

- **What's the difference between a service area and a provider network?**

  A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a group of doctors, hospitals and other providers who contract with Anthem to provide discounted fees for their services. In a POE plan, you must use only network providers. In a POS plan, you can use network and non-network providers, but you pay less when you use network providers.

- **What are my options if I want access to doctors anywhere in the U.S.?**

  Anthem offers extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you can choose the Anthem Out-of-Area plan, which has a national network.

- **How do I find out which networks my doctor is in?**

  Contact Health Navigator at 866-611-8005 to find out if your doctor is in the network of the plan you're considering. You can search online at CareCompass.CT.Gov, or you can call customer service at the numbers on page 56. It's likely your doctor participates in more than one network.



## Dental Coverage

- **What's the difference between the Cigna Dental Care DHMO Plan and the Total Care DHMO Plan?**

  If you're enrolled in the Cigna Dental Care DHMO Plan, you pay copays when you need care. If you're enrolled in the Total Care DHMO Plan, you pay coinsurance when you need care.

- **How do I know which dental plan is best for me?**

  This is a question only you can answer. Each plan offers different advantages. To choose the plan that is best for you, compare the plan-to-plan features in the *Dental Coverage at a Glance* table on page 29 and weigh your priorities.

- **How long can my children stay on the dental plan? Can they stay covered through the end of the calendar year in which they turn age 26, like with the medical plans?**

  The Affordable Care Act extended benefits for children through the end of the calendar year in which they turn age 26 only under medical and prescription drug coverage, not dental coverage. Dental coverage ends for dependent children at age 19. For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits and before their 26th birthday for medical benefits.*

** For your disabled child to remain an eligible dependent, he/she must be certified as disabled by Anthem before he/she becomes age 19 (for dental benefits; age 26 applies only for medical benefits).*

- **Do any of the dental plans cover orthodontia for adults?**

  Yes, the Enhanced Plan, Cigna Dental Care DHMO Plan, and Total Care DHMO Plan cover orthodontia for adults, up to certain limits. The Enhanced Plan pays $1,500 per person (adult or child) per lifetime. The Cigna Dental Care DHMO requires a copay. The Total Care DHMO requires coinsurance. The Basic Plan does not cover orthodontia for adults or children.

- **If I participate in HEP, are my regular dental cleanings covered 100%?**

  Yes, up to two cleanings per year are covered 100%. However, if you are in the Enhanced Plan, you must use an in-network dentist to receive 100% coverage. If you go out of the network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge). If you enroll in either DHMO, you must use a network dentist or your exam and cleaning won't be covered (except in cases of emergency).

# Coverage for Individuals Eligible for Medicare

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 and You

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 enroll you automatically in the UnitedHealthcare Group Medicare Advantage (PPO) plan. Your state-sponsored medical and prescription coverage through the UnitedHealthcare Group 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 UnitedHealthcare Group 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. Medicare premiums paid before a copy of your card is received will not be reimbursed. For 2021, the standard Medicare Part B/Part D premium reimbursement is $148.50.

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.

**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.

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

1. **The UnitedHealthcare Group Medicare Advantage plan is your only option for state-sponsored medical and prescription drug coverage.** If you opt out of the UnitedHealthcare plan, you opt out of your state-sponsored coverage. UnitedHealthcare 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.**
2. **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 UnitedHealthcare Group 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 UnitedHealthcare Group Medicare Advantage plan and cause your state-sponsored medical and pharmacy coverage to end for you and your dependents.**
3. **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.
4. **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 UnitedHealthcare Group 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 UnitedHealthcare.

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 UnitedHealthcare Group 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 UnitedHealthcare directly, **NOT** to Medicare. Then, your UnitedHealthcare plan pays for your care. This is why it is very important for you to use your UnitedHealthcare plan member ID card when you need health care services.

Please refer to the UnitedHealthcare Group 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 or later

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

*[1] Only select brands are covered: OneTouch® Ultra® 2, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio IQ®, OneTouch Verio® Flex™, Accu-Chek® Guide, Accu-Chek Aviva Plus, Accu-Chek Nano SmartView, Accu-Chek Aviva Connect*

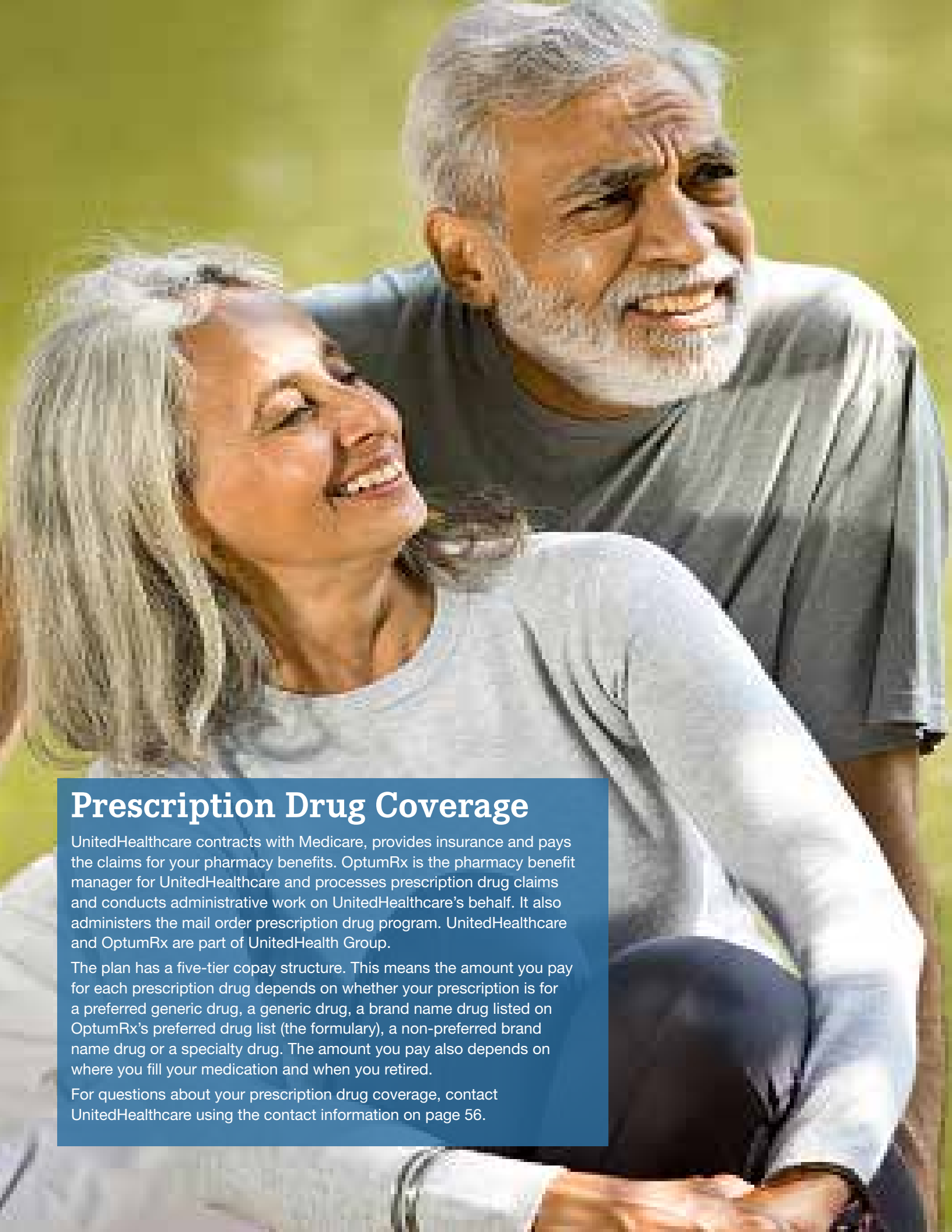
*[2] Benefits are combined in- and out-of-network.*

*[3] You must use the UnitedHealthcare Hearing network provider to access hearing aid benefits.*

# UnitedHealthcare Additional Programs

- **Call NurseLine 24/7.** If you have a question about a medication or a health concern, call NurseLine 24/7 at 877-365-7949. A registered nurse will take your call.
- **Renew Rewards: Complete an annual physical or wellness visit—and earn a reward!** Earn gift cards for completing healthy activities, like an annual physical or wellness visit. Your visit is covered 100% by the plan—you'll pay a $0 copay. To receive your gift card reward, complete your annual physical or wellness visit between January 1, 2021 and September 30, 2021.Let UnitedHealthcare know you completed your visit by registering online at UHCRetiree.com/CT or by phone toll-free at 888-803-9217, 8 a.m. – 8 p.m. ET, Monday – Friday. Your visit must be reported by December 31, 2021 to be eligible for a gift card.
- **HouseCalls: Enjoy a clinical visit in the comfort of your own home.** UnitedHealthcare HouseCalls is an annual wellness program offered at no extra cost. The program sends an advanced practice clinician—a nurse practitioner, physician assistant or medical doctor—to your home for up to one hour of one-on-one time. During the visit, the clinician will:
  - Provide a personalized health screening, nutrition and wellness tips, and educational materials
  - Review your medical history and help you prepare for any upcoming doctor visits
  - Assist you with creating personalized health goals or a healthy action plan

  HouseCalls will then send a summary of your visit to your primary care provider so he/she has this information about your health. Plus, when you complete a HouseCalls visit, you can receive a $15 gift card! (**Note:** HouseCalls may not be available in all areas.)
- **Solutions for Caregivers: Make caring for a loved one easier.** At no additional cost, Solutions for Caregivers supports you, your family and those you care for by providing information, education, resources and care planning. Also included is an on-site evaluation by a registered nurse and a personal plan of care developed by a geriatric case manager. You will also have access to UHC's Caregiver Partners website so you can explore the UHC library of articles, buy caregiver-related products and services, and share information among family members to help improve communication and decision-making.
- **Virtual Doctor Visits: Chat with a doctor through online video chat—24/7.** Use your computer, tablet or smartphone to speak with a board-certified doctor anytime, anywhere. You can ask questions, get a diagnosis and even get medications sent to your local pharmacy. Virtual Doctor Visits are covered 100% by the plan—you'll pay a $0 copay. Speak virtually with a doctor about non-life-threatening health concerns, like allergies, colds/coughs, pinkeye, rashes, fevers, flu, sore throats, diarrhea, migraines, stomachaches, and more! To sign up, call UnitedHealthcare Customer Service toll-free at 888-803-9217, 8 a.m. – 8 p.m. ET, Monday – Friday. Get more details at UHCvirtualvisits.com or UHCRetiree.com/CT.
- **Go beyond the plan benefits to live your best life.** We all want to live a healthier, happier life. Renew by UnitedHealthcare can be your guide. Renew, our member-only Health & Wellness Experience, includes inspiring lifestyle tips, learning activities, videos, recipes, interactive health tools, rewards and more, all designed to help you live your best life. Explore all that Renew has to offer by logging in to UHCRetiree.com/CT.
- **Get active and have fun with SilverSneakers® Fitness.** Designed for all fitness levels and abilities, SilverSneakers includes access to exercise equipment, classes and more at 13,000+ fitness locations. SilverSneakers signature classes, offered at select locations, are led by certified instructors trained specifically in adult fitness and include a range of options from using light hand weights to more intense circuit training.



# Prescription Drug Coverage

UnitedHealthcare contracts with Medicare, provides insurance and pays the claims for your pharmacy benefits. OptumRx is the pharmacy benefit manager for UnitedHealthcare and processes prescription drug claims and conducts administrative work on UnitedHealthcare's behalf. It also administers the mail order prescription drug program. UnitedHealthcare and OptumRx are part of UnitedHealth Group.

The plan has a five-tier 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 OptumRx'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 UnitedHealthcare using the contact information on page 56.

# Prescription Drug Coverage at a Glance

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

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

*[2] Maintenance drugs for Group 4 and Group 5 are covered up to a 90-day supply.*

*[3] 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 UnitedHealthcare'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 OptumRx. If new generics have become available, new clinical studies have been released or new brand name drugs have become available, OptumRx may change the tier placement of a drug.

## 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 UnitedHealthcare Customer Service at 888-803-9217 (TTY 711), 9 a.m. – 9 p.m. ET, Monday – Friday. 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 OptumRx 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 OptumRx for more information.

# Dental Coverage

Cigna is the dental carrier for the State of Connecticut's three dental plans:

- ***New!* Total Care DHMO Plan.** This plan provides dental services only from a defined network of dentists and pays benefits only when you receive care from a network dentist (except in cases of emergency). You must select a primary care dentist. He/she will coordinate your care. Referrals are required for all specialist services. There's no annual deductible or calendar-year maximum. When you need care, you pay coinsurance based on the service you receive.
- **Enhanced Plan.** This plan also allows you to visit any dentist or dental specialist without a referral but pays a different level of benefits than the Basic Plan.
- **Cigna Dental Care DHMO Plan.** This plan provides dental services only from a defined network of dentists and pays benefits only when you receive care from a network dentist. You must select a primary care dentist. He/she will coordinate your care. Referrals are required for all specialist services. There's no annual deductible or calendar-year maximum. When you need care, you pay copays based on the service you receive.
- **Basic Plan.** This plan allows you to visit any dentist or dental specialist without a referral.

> Many of the Basic and Enhanced Plan network dentists have agreed to offer their discounted fees to you and your enrolled dependents for non-covered services. You must visit network dentists to receive the discounts (savings will not apply for care received from non-participating dentists). Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment. You are responsible for paying the negotiated fees directly to the dentist.

# Dental Coverage at a Glance

| | Total Care DHMO Plan | Enhanced Plan | Cigna Dental Care DHMO Plan | Basic Plan |
|---|---|---|---|---|
| **Annual deductible** | None | Individual: $25<br>Family: $75<br>The deductible does not apply to routine exams, cleanings and x-rays | None | None |
| **Annual benefit maximum** | None | $3,000 per person; excluding orthodontia | None | None; $500 per person for periodontics |
| **Routine exams, cleanings, x-rays** | Plan pays 100% | Plan pays 100%[1] | Covered[2] | Plan pays 100% |
| **Periodontal maintenance** | 15% coinsurance, plan pays 85% | Plan pays 100%[1] | Covered[2] | 20% coinsurance, plan pays 80%<br>If retired after 10/1/2011: Plan pays 100% |
| **Periodontal root scaling and planing** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[2] | 50% coinsurance, plan pays 50% |
| **Other periodontal services** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[2] | 50% coinsurance, plan pays 50% |
| **Simple restorations** | | | | |
| **Fillings** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[2] | 20% coinsurance, plan pays 80% |
| **Oral surgery** | 15% coinsurance, plan pays 85% | 20% coinsurance, plan pays 80% | Covered[2] | 33% coinsurance, plan pays 67% |
| **Major restorations** | | | | |
| **Crowns** | 30% coinsurance, plan pays 70% | 33% coinsurance, plan pays 67% | Covered[2] | 33% coinsurance, plan pays 67% |
| **Dentures, fixed bridges** | 45% coinsurance, plan pays 55% | 50% coinsurance, plan pays 50% | Covered[2] | Not covered[3] |
| **Implants** | 45% coinsurance, plan pays 55% (one per year) | 50% coinsurance, plan pays 50% (maximum of $500) | Covered[2] | Not covered[3] |
| **Orthodontia** | 45% coinsurance, plan pays 55% | Plan pays a maximum of $1,500 per person per lifetime[4] | Covered[2] | Not covered[3] |

*[1] You must use an in-network dentist to receive 100% coverage; if you use an out-of-network dentist, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.*

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

*[3] While these services are not covered, you will get the discounted rate on these services if you visit an in-network dentist, unless prohibited by state law.*

*[4] Benefits prorated over the course of treatment.*

### myCigna Mobile App

Download the myCigna mobile app on Google Play (Android) or the App Store (Apple) to get access to your personal information on the go. Through the app, you can find care and costs, view claims, update your personal information and more!

# Comparing Your Dental Coverage Options

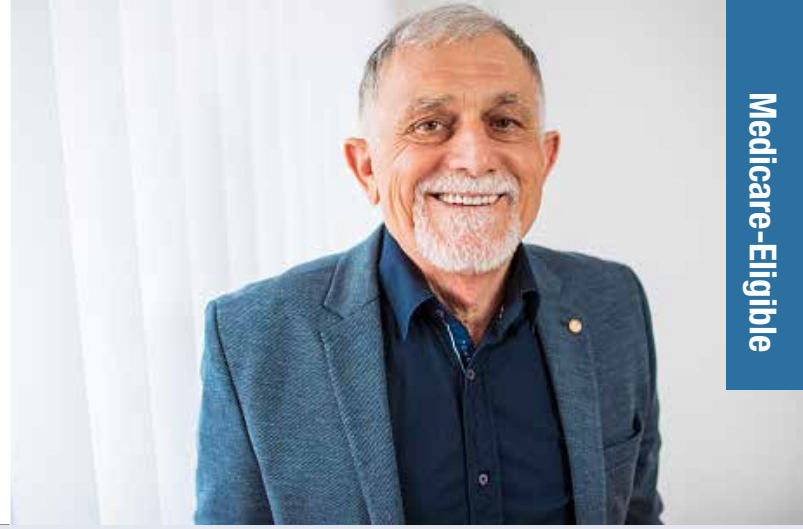
| | Cigna Dental Care DHMO Plan and Total Care DHMO Plan | Enhanced Plan | Basic Plan |
|---|---|---|---|
| **Can I receive services from any dentist?** | No, all services must be received from a contracted in-network dentist | Yes, but you will pay less when you choose an in-network provider | Yes, but you will pay less when you choose an in-network provider |
| **Do I need a referral for specialty dental care?** | Yes | No | No |
| **Will I pay a flat rate for most services?** | Yes | No, you will pay a percentage of the cost of most services after you reach your annual deductible | No, you will pay a percentage of the cost of most services |
| **Must I live in a certain service area to enroll?** | Yes, you must live in the DHMO's service area | No | No |
| **Is orthodontia covered?** | Yes | Yes | No |
| **Are dentures or bridges covered?** | Yes | Yes | No |

### Consider the Cigna Dental Care DHMO Plan or Total Care DHMO Plan

The DHMO network continues to grow! Did you know that many retirees enrolled in the Basic and Enhanced plans are already seeing DHMO providers? Be sure to check your provider's status at cigna.com/stateofct. Enrolling in the DHMO could help you save money.

### Need help choosing a dental plan?

Try Cigna's decision support tool: zingtree.com/show/233326574000.



## Pretreatment Estimates

Before starting extensive dental procedures for which the dentist's charges may exceed $200, you can ask your dentist to submit a pretreatment estimate to the plan. You can also help to determine the amount you will be required to pay for a specific procedure by using the plan's website. More details about covered expenses are available by contacting Cigna at 800-244-6224 or cigna.com/stateofct.

## Cigna Dental Programs

- **Oral Health Integration Program®.** Enrolled retirees and dependents have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program (OHIP). With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services. Qualifying medical conditions for OHIP include heart disease, stroke, diabetes, pregnancy, chronic kidney disease, organ transplants, and head and neck cancer radiation. For additional information about OHIP, visit cigna.com/stateofct.
- **Healthy Rewards®.** Cigna's Healthy Rewards program provides discounts of up to 60% on health-related programs and services.There's no time limit or maximum for these instant savings when you visit a participating provider or shop online. No referrals or claim forms are needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins. Learn more about Healthy Rewards at cigna.com/rewards (password: savings) or by calling 800-258-3312.

# Frequently Asked Questions

## General

- **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 UnitedHealthcare at the phone number or website listed on page 56.

- **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 UnitedHealthcare Group 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, UnitedHealthcare is the administrator through the UnitedHealthcare Group 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 UnitedHealthcare Group 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 UnitedHealthcare ID card. It also means that each UnitedHealthcare plan member will receive his or her own set of plan documents.

## Medical

- **Is the UnitedHealthcare Group 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 UnitedHealthcare Group 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 UnitedHealthcare ID card each time you receive medical services or fill a prescription.

- **How are claims processed?**

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

- **Is the UnitedHealthcare Group 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 UnitedHealthcare for reimbursement after returning to the U.S.

## Dental Coverage

- **What's the difference between the Cigna Dental Care DHMO Plan and the Total Care DHMO Plan?**

  If you're enrolled in the Cigna Dental Care DHMO Plan, you pay copays when you need care. If you're enrolled in the Total Care DHMO Plan, you pay coinsurance when you need care.

- **How do I know which dental plan is best for me?**

  This is a question only you can answer. Each plan offers different advantages. To help choose which plan might be best for you, compare the plan-to-plan features in the *Dental Coverage at a Glance* table on page 47, and weigh your priorities.

- **Can I enroll later or switch plans midyear?**

  Generally, the elections you make now are in effect July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections midyear (see page 7). If you decline coverage now, you can enroll during any later Open Enrollment or if you experience certain qualifying status changes.

- **How long can my children stay on the dental plan? Can they stay covered through the end of the calendar year in which they turn age 26, like with the medical plans?**

  The Affordable Care Act extended benefits for children through the end of the calendar year they turn age 26 only under medical and prescription drug coverage, not dental. Dental coverage ends for dependent children at age 19. For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

- **Do any of the dental plans cover orthodontia for adults?**

  Yes, the Total Care DHMO plan, the Enhanced Plan and the Cigna Dental Care DHMO all cover orthodontia for adults up to certain limits. The Total Care DHMO plan covers 55% of the cost with an in-network provider. The Enhanced plan pays $1,500 per person per lifetime and covers 50% of the cost for adults and children. The Cigna Dental Care DHMO requires a copay. The Basic Plan does not cover orthodontia for adults or children.

** For your disabled child to remain an eligible dependent, he/she must be certified as disabled by Anthem before he/she becomes age 19 (for dental benefits; age 26 applies only for medical benefits).*

# 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.
- **Dependent.** A family member who meets the eligibility criteria established by the State of Connecticut Retiree Health Plan for plan enrollment.
- **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.
- **Effective date.** The calendar year your health care coverage begins. You are not covered until your effective date.
- **Premium contribution.** The amount you must pay on a monthly basis toward the cost of health care. This is withdrawn automatically from your monthly pension check.
- **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.
- **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

1. **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 Care Compass at CareCompass.CT.Gov.
2. **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.
3. **If you're enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) plan, you do not need to use your red, white and blue Medicare card.** You should use your UnitedHealthcare Group 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 UnitedHealthcare ID card each time you receive medical services or fill a prescription.
4. **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 UnitedHealthcare Group 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 UnitedHealthcare Group 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."
5. **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 premium-free Medicare Part A hospital insurance and Medicare Part B medical insurance.
6. **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 UnitedHealthcare Group 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.
7. **Medicare-eligible members must pay premiums to the federal government.** 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.
8. **Premiums for coverage must be paid, if applicable.** Premiums you must pay for non-Medicare-eligible health coverage or dental coverage will be deducted automatically 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.
9. **You must disenroll ineligible dependents within 31 days after the date they become ineligible.** Find more information on qualifying status changes on page 7. If you continue to cover an ineligible dependent after the 31-day period, you may be charged a fine.
10. **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<br>Retiree Health Insurance Unit | 860-702-3533 | CareCompass.CT.Gov |
| **Coverage for Non-Medicare-Eligible Individuals** | | | |
| **General benefit questions** | Health Navigators | 866-611-8005 | CareCompass.CT.Gov |
| **Medical** | Anthem Blue Cross and Blue Shield<br>• Anthem State BlueCare Prime Plus POS<br>• Anthem State BlueCare POE<br>• Anthem State BlueCare POE Plus (POE-G)<br>• Anthem Out-of-Area<br>• Anthem State BlueCare POS | 800-922-2232 | anthem.com/statect |
| **Prescription drugs** | CVS Caremark | 800-318-2572 | caremark.com |
| **Health Enhancement Program (HEP)** | Care Management Solutions | 877-687-1448 | cthep.com |
| **Dental** | Cigna<br>• Basic Plan<br>• Enhanced Plan<br>• Cigna Dental Care DHMO Plan<br>• Total Care DHMO Plan | 800-244-6224 | cigna.com/stateofct |
| **Coverage for Medicare-Eligible Individuals** | | | |
| **Medical and prescription drugs** | UnitedHealthcare<br>• Group Medicare Advantage (PPO) plan | 888-803-9217<br>TTY 711<br>9 a.m. – 9 p.m. ET Monday – Friday<br>Behavioral Health: 800-453-8440 | UHCRetiree.com/CT |
| **Dental** | Cigna<br>• Basic Plan<br>• Enhanced Plan<br>• Cigna Dental Care DHMO Plan<br>• Total Care DHMO Plan | 800-244-6224 | cigna.com/stateofct |

# Notes

# RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744-OE REV. 3/2021

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

**Type or print and forward to the Retirement Health Insurance Unit.**

You must submit a completed enrollment application and any required documentation to the Retirement Health Insurance Unit **within 30 days** of your initial benefits eligibility date or **within 30 days** of a qualified change in family status. Please refer to https://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** (M/F) | **Home Telephone Number** |
|---|---|---|---|
| | | | |

| **Email Address** | **Cell/Mobile Telephone Number** |
|---|---|
| | |

## ② Application Type

☐ New Retirement Enrollment
☐ Annual Open Enrollment
☐ Adding/Dropping Dependents

Qualifying Status Change:
☐ Marriage
☐ Birth/Adoption
☐ Change in Dependent Eligibility Status

Date of Event: ____/ ____/ _____
☐ Start of Other Coverage
☐ Loss of Other Coverage
☐ Death of Spouse/Dependent

## ③ Your Medicare Information

Complete this section if you are eligible for Medicare and would like to enroll in state-sponsored medical and prescription coverage. If you are not yet eligible for Medicare, leave this section blank.

| **Medicare Claim Number** (as it appears on your card) | **Medicare Part A Effective Date** (MM/DD/YYYY) | **Medicare Part B Effective Date** (MM/DD/YYYY) | **End Stage Renal Diagnosis** ☐ **Yes** ☐ **No** |
|---|---|---|---|
| | | | |

## ④ 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.

☐ Anthem State BlueCare POE Plus POE-G
☐ Anthem State BlueCare POE
☐ Anthem State BlueCare Prime Plus POS
☐ Anthem State BlueCare POS
☐ Anthem State Preferred POS – **Currently Enrolled Only**
☐ Anthem Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**
☐ No Change – Keep Current Medical Benefit Plan
☐ Waive/Cancel Medical and Prescription Coverage

## ⑤ Choose Your Dental Plan

☐ Basic Dental Plan ☐ Enhanced Dental Plan ☐ Total Care DHMO Plan *New* ☐ Cigna Dental Care DHMO Plan ☐ Waive/Cancel Dental Coverage ☐ No Change – Keep Current Dental Plan

## ⑥ 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** |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ |

## ⑦ Dependent Medicare Information

List all Medicare eligible dependents, attach additional sheet if necessary. If no dependents are eligible for Medicare, leave this section blank.

| **Name** | **Medicare Claim Number** (as it appears on Medicare card) | **Medicare Part A Effective Date** (MM/DD/YYYY) | **Medicare Part B Effective Date** (MM/DD/YYYY) | **End Stage Renal Diagnosis** ☐ **Yes** ☐ **No** |
|---|---|---|---|---|
| | | | | |

## ⑧ Signature & 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** |
|---|---|
| | |

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

CARE COMPASS

CareCompass.CT.gov

April 2021