2023/2024 Health Care Options Planner

State of Connecticut Retirees

CARE COMPASS

CareCompass.CT.gov

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 28**). Within each section, benefit information is grouped by retirement date. Your retirement date falls into one of the following groups:

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 or later

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

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

Sean Scanlon
State Comptroller
@CTComptroller

Welcome!

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

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

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

Sean Scanlon

Connecticut State Comptroller

Want to learn more?

Join a Retiree Live Event:

- May 24, 2023: 12:30 to 1:30 p.m. ET
- Visit **CareCompass.CT.gov/benefits-enrollment** for the meeting link and additional information.

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Your 2023 Open Enrollment Checklist

Open Enrollment is **May 1** through **May 26, 2023**, for benefits effective July 1, 2023. Complete this list before the May 26 deadline to get a better understanding of the 2023 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 **pages 9 and 10** (even if you are not making any changes to your coverage elections).
- √ Pay careful attention to the *What's New Starting July 1, 2023* section on **page 2**—it provides an overview of the 2023 changes to your health care coverage.
- √ If you decide to make changes, complete the Retiree Health Enrollment/ Change Form (CO-744-OE) on **page 45** 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 a personal Care Coordinator at 833-740-3258.

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, 2023

Introducing Quantum Health

For those enrolled in **Anthem non-Medicare-eligible medical plans**, Quantum gives you access to:

- A **benefit portal** with your personal information, including Health Enhancement Program (HEP requirements.
- **Personalized assistance** from Care Coordinators. They're standing by to help with your health care needs, including questions about condition management, HEP, claims, providers and coverage.

With new features on the way:

- An advanced, custom-built **provider search tool** to help you locate in-network providers across all State benefits
- **One-click access** from the benefit portal to personalized CVS, Anthem and Cigna websites.
- A **one-stop shop** for prior authorizations and precertifications for physical therapy and occupational therapy.

To register for your benefits portal:

- Go to **CareCompass.CT.gov** and select **Create an Account.** Then, register using the last four digits of your Medical ID (found on your Anthem card).

Contact a Care Coordinator

- Contact a Care Coordinator at 833-740-3258. Log in to the benefit portal **(carecompass.quantum-health.com**) to send a secure message to a Care Coordinator. If it is your first time accessing the benefit portal, select Register and create an account.

New Anthem Medical ID Cards

Even if you do not change plans, all medical plan members will receive a new Anthem ID card that provides the Quantum Member Services phone number and Care Compass website by 7/1.

Newly Designed Care Compass Site

It's now easier access to benefit portal, review open enrollment information, and access member services contact information.

Benefit Changes

There are no benefit changes for 2023.

Benefit Option Reminders

Dental Benefits

Dental Plans

All retirees have the same dental coverage options available:

- **Cigna Dental Care DHMO Plan**
- **Total Care DHMO Plan**
- **Enhanced Plan**
- **Basic Plan**

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

Dependent Dental Coverage Extended to Age 26

Eligible dependents can remain enrolled in State sponsored dental coverage through the end of the year in which they turn age 26.

Non-Medicare-Eligible Coverage Changes

Medical Plans

- **Primary Care Access**
  Anthem name: State BlueCare Point of Enrollment Plus (POE-G Plus)
- **Standard Access**
  Anthem name: State BlueCare Point of Enrollment (POE)
- **Expanded Access**
  Anthem name: State BlueCare Point of Service (POS)
- **Quality First Select Access**— Anthem name: State BlueCare Prime Tiered POS

Quality First Select Access Plan

The Quality First Select Access plan uses the same Prime network as the State BlueCare Prime Plus POS; however, this network uses a tiering system for providers. Plus, you do not need to select a PCP or get a referral to see a specialist in the Quality First Select Access plan.

Search the State BlueCare Prime network to ensure your doctors and specialists are in this plan. To save on out-of-pocket costs, use providers marked Value Tier 1—you'll pay a $0 copay. With a Tier 2 provider, you'll pay more for care: $50 copay for PCPs and $100 copay for specialists. Hartford HealthCare facilities and providers are NOT in this plan's network.

2023 Open Enrollment Overview

Open Enrollment: May 1 through May 26, 2023

Changes Effective: July 1, 2023 through June 30, 2024

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…
• Quality First Select Access (State BlueCare Prime Tiered POS) • Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus]) • Standard Access (State BlueCare Point of Enrollment [POE]) • Expanded Access (State BlueCare Point of Service [POS]) • State Preferred Point of Service (POS) – closed to new enrollment • Out-of-Area (available only if retiree's permanent address is outside Connecticut)	• Make a change to your medical coverage until the Medicare Open Enrollment period in October 2023. You will receive more information prior to the Medicare Open Enrollment period.
You can…	You can…
• Enroll in or make changes to your non-Medicare-eligible medical plan (listed above) • Add or change your dental plan option • Add or drop dependents from medical and dental coverage	• Add or change your dental plan option • Add or drop dependents from medical and dental coverage
By submitting by May 26...	By submitting by May 26...
• A completed Retiree Health Enrollment/Change Form (CO-744-OE) • Any required documentation supporting the addition of an eligible dependent	• A completed Retiree Health Enrollment/Change Form (CO-744-OE) • Any required documentation supporting the addition of an eligible dependent

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

Enrolling in Retiree Health Benefits

2023 Open Enrollment is May 1 through May 26, 2023, for coverage effective July 1, 2023 through June 30, 2024.

Current Retirees

If you are a retiree, you and your dependents who are Medicare-eligible are automatically enrolled in the Aetna Medicare Advantage PPO plan. You and 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 45** of this Planner and return it to the Retiree Health Insurance Unit.

New Retirees

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

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

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

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

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

Waiving Coverage

If you have other medical coverage and want to waive State of Connecticut coverage when 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.

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

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.

The Retiree Health Enrollment/Change Form (CO-744-OE) is available on **page 45** of this Planner and online at **CareCompass.CT.gov**.

Dependent

It's important to understand whom 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. **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 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. (Not required if you are a new retiree enrolling for the first time.)
- Disabled child must meet the requirements of being an eligible dependent child before turning age 26. (Not required if you are a new retiree enrolling for the first time.)
- Adult child must have been physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled since age 26.
- Adult child is dependent on the member for substantially all of their economic support and is declared as an exemption on the member's federal income tax return.
- Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter and upon request.
- All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify the Retiree Health Insurance Unit of any dependent's eligibility for, and enrollment in, Medicare.

Retiree 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).

Once you enroll your disabled adult child, you must continuously enroll that 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.

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 6**.

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 immediately notify the Retiree Health Insurance Unit. 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 • Copy of a marriage certificate (issued in the U.S.) • Birth certificate for any of your spouse's children you plan to cover • A Social Security number for anyone you are adding to your coverage • Proof of Medicare enrollment (if applicable)	First day of the month following the event date
Birth or adoption	• Completed enrollment application • Copy of the birth certificate or adoption documentation	Newborn child: First of the month following the child's date of birth Adopted child: The date the child is placed with you for adoption
Legal guardianship or court order	• Completed enrollment application • 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 • Copy of the legal documentation of your family status change	Coverage will terminate on the first day of the month following the date on which the divorce or legal separation occurred
By law, you must disenroll ineligible dependents within 31 days after the date of a divorce or legal separation. Failure to notify the Retiree Health Insurance Unit can result in significant financial penalties.		
Loss of other health coverage	• Completed enrollment application • Proof of loss of coverage (documentation must state the date your other coverage ends and the names of individuals losing coverage)	First of the month following your loss of coverage
Obtaining other health coverage	• Completed enrollment application • Proof of enrollment in other health coverage (documentation must indicate the effective date of coverage and the names of enrolled individuals)	Coverage will terminate on the first of the month following the event date. Note: You must pay premium contributions up to the termination date of your retiree health coverage
Moving out of your plan's service area (non-Medicare-eligible coverage only)	Address Change Form (CO-1082), available at: **osc.ct.gov**	Coverage under the new plan will be effective the first of the month following the date you permanently moved
If you or a covered dependent has Medicare-eligible coverage, you must live in the U.S. in order to be covered by the plan.		
Death of a dependent	Copy of the death certificate	Coverage terminates the day after the dependent's death

Cost of Coverage

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

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

Calculating Your Medical Premium Contribution Rate

All Covered Individuals Eligible for Medicare

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

Split Families

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 you are enrolled in a plan that requires monthly premium contributions.

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

All Covered Individuals Not Eligible for Medicare

You 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 9** to see if you or your dependents are covered under a plan that requires premiums. If yes, determine your monthly premium amount by identifying the number of individuals covered under that plan.

Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage

Coverage Level	Quality First Select Access (State BlueCare Prime Tiered POS)	Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus])	Standard Access (State BlueCare Point of Enrollment [POE])	Expanded Access (State BlueCare Point of Service [POS])	Anthem State Preferred POS*	Anthem Out-of-Area
Group 1: Retirement date prior to July 1999						
1 person	$0	$0	$0	$0	$0	$0
2 persons	$0	$0	$0	$0	$0	$0
3+ persons	$0	$0	$0	$0	$0	$0
Group 2: Retirement date 7/1/99 – 5/1/09, and those under the 2009 RIP						
1 person	$18.22	$0	$0	$20.03	$21.30	$0
2 persons	$40.08	$0	$0	$44.07	$46.86	$0
3+ persons	$49.18	$0	$0	$54.09	$57.51	$0
Group 3: Retirement date 6/1/09 – 10/1/11						
1 person	$18.22	$0	$0	$20.03	$21.30	$0
2 persons	$40.08	$0	$0	$44.07	$46.86	$0
3+ persons	$49.18	$0	$0	$54.09	$57.51	$0
Group 4: Retirement date 10/2/11 – 10/1/17						
1 person	$18.22	$0	$0	$20.03	$21.30	$0
2 persons	$40.08	$0	$0	$44.07	$46.86	$0
3+ persons	$49.18	$0	$0	$54.09	$57.51	$0
Group 5a: Retirement date 10/2/17 – 7/1/2022; 25 or more years of service OR hazardous duty						
1 person	$17.64	$0	$0	$19.04	$20.28	$0
2 persons	$38.81	$0	$0	$41.89	$44.61	$0
3+ persons	$47.63	$0	$0	$51.42	$54.74	$0
Group 5b: Retirement date 10/2/17 – 7/1/2022; fewer than 25 years of service OR non-hazardous duty						
1 person	$35.28	$18.51	$18.68	$38.09	$40.55	$20.28
2 persons	$77.61	$40.73	$41.10	$83.79	$89.21	$44.61
3+ persons	$95.25	$49.98	$50.44	$102.83	$109.49	$54.74
Group 5c: Retirement date August 1, 2022 or later; hazardous duty						
1 person	$35.28	$37.02	$37.36	$38.09	$40.55	$40.55
2 persons	$77.61	$81.45	$82.20	$83.79	$89.21	$89.21
3+ persons	$95.25	$99.97	$100.88	$102.83	$109.49	$109.49
Group 5d: Retirement date August 1, 2022 or later; non-hazardous duty						
1 person	$58.80	$61.71	$62.27	$63.48	$67.59	$67.59
2 persons	$129.35	$135.76	$137.00	$139.65	$148.69	$148.69
3+ persons	$158.75	$166.61	$168.13	$171.38	$182.48	$182.48

** 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 21 – 22.**

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

Coverage Level	Cigna Dental Care DHMO Plan	Total Care DHMO Plan	Enhanced Plan	Basic Plan
All Retirement Groups				
1 person	$23.38	$29.16	$34.15	$42.54
2 persons	$51.45	$64.15	$68.30	$85.09
3+ persons	$63.14	$78.74	$68.30	$85.09

Using Your Benefits

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

When you need information about your benefits…

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

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

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

Chat with a Care Coordinator.

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

When you need support…

If you're a pre-65 (non-Medicare-eligible) retiree or dependent, you can speak with a Care Coordinator (833-740-3258) for help understanding your benefits, finding a doctor, and dealing with the complexities of health care. Quantum Health makes it easier for you to navigate your benefits and access the right care for you by coordinating with the member service teams at Anthem, Cigna, and CVS Caremark. Chat with a Care Coordinator 8:30 a.m. – 10 p.m., Monday – Friday, at 833-740-3258, or send a secure message through your benefits portal.

Coverage for Individuals NOT Eligible for Medicare

Medical Coverage

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

- **Quality First Select Access (State BlueCare Prime Tiered POS):** A PCP and referrals to specialists are not required.
- **Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus]):** A PCP is required; you must have a referral to see a specialist. Out-of-network services are not covered, except in an emergency.
- **Standard Access (State BlueCare Point of Enrollment [POE]):** A PCP and referrals to specialists are not required. Out-of-network services are not covered, except in an emergency.
- **Expanded Access (State BlueCare Point of Service [POS]):** A PCP and referrals to specialists are not required.
- **State Preferred Point of Service (POS):*** A PCP and referrals to specialists are not required.
- **Out-of-Area (OOA):** Available if you move out of Connecticut.

Understanding the Plans

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

Ask yourself these questions:

- Am I okay with selecting a primary care physician to coordinate my care?
- Am I okay with seeking a referral before seeing a specialist?
- Do I need out-of-network options for care?
- Would I rather pay more in bimonthly premiums or more out of pocket when I need care?
- Are my current providers in the network? If you're not sure, search for your providers using **Anthem's Find Care tool**.

Need help choosing a plan?

Visit **carecompass.ct.gov/decisionguide** to use our medical plan decision support tool!

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

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

Allowable Charge

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

Need more help choosing a plan?

Contact a Care Coordinator (833-740-3258) for help choosing the best medical plan for you and your enrolled family members.

** The State Preferred Point of Service plan is closed to new enrollments. The Out-of-Area plan is only available if you move out of state.*

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

The Quality First Select Access Plan

The Quality First Select Access plan (State BlueCare Prime Tiered POS) 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 Tiered POS network. If you enroll in the Quality First Select Access plan (State BlueCare Prime Tiered POS), you must select a primary care physician (PCP) in the State BlueCare Prime Tiered POS network. Check **anthem.com/statect/find-care** to see if your current PCP or specialists are preferred providers with the plan.

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

Benefit Features		Quality First Select Access		
		In-Network Value Tier 1	In-Network Tier 2	Out-of-Network[1]
Office visit[2]		You pay $0	PCP: You pay $50 Specialist: You pay $100	You pay 20%, plus deductible
LiveHealth Online (telemedicine)		You pay $0	N/A	N/A
Preventive care		You pay $0	You pay $0	You pay 20%, plus deductible
Walk-In Clinic/Urgent Care Center[3]		You pay $35	You pay $35	You pay 20%, plus deductible
Emergency care (waived if admitted)		You pay $250	You pay $250	You pay $250
Diagnostic lab	Site of Service[6]	You pay $0	You pay $0	N/A
	Non-Site of Service	You pay 20%	You pay 20%	You pay 40%, plus deductible
Diagnostic x-ray (prior authorization required for diagnostic imaging)		You pay $0	You pay $0	You pay 20%, plus deductible
Inpatient physician/hospital (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient surgical facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Ambulance (if emergency)		You pay $0	You pay $0	You pay $0
Short-term rehabilitation and physical therapy (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Routine eye exam (one exam per year)		You pay $0	You pay $50[4]	You pay 50%, plus deductible
Audiology screening (one exam per year)		You pay $0	You pay $50	You pay 20%, plus deductible
Inpatient Mental Health/Substance Abuse (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient Mental Health/ Substance Abuse		You pay $0	You pay $0	You pay 20%, plus deductible
Family planning: vasectomy or tubal ligation (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Durable medical equipment (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Skilled nursing facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Home health care (up to 200 visits per year; prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Annual deductible		$0[5]		Individual: $500[5] Family: $1,500[5]
Annual out-of-pocket maximum		Individual: $3,000 Family: $6,000		Individual: $6,000 Family: $12,000

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

[2] PCP telemedicine visits are covered the same as office visits.

[3] Hartford Hospital Centers are considered out-of-network.

[4] Health Enhancement Program participants have $50 copay waived once every two years.

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

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

All Other Medical Plans: In-Network

- Expanded Access
- Primary Care Access
- Standard Access
- State Preferred Point of Service (POS)*
- Out-of-Area

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

** Closed to new enrollments.*

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

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

[3] Prior authorization may be required.

[4] Subject to medical necessity review.

[5] Health Enhancement Program participants have $15 copay waived once every two years.

All Other Medical Plans: In-Network *continued*

- Expanded Access
- Primary Care Access
- Standard Access
- State Preferred Point of Service (POS)*
- Out-of-Area

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

** Closed to new enrollments.*

[3] Prior authorization may be required.

[6] Waived for HEP-compliant members.

Out-of-Network

- State Preferred Point of Service (POS)*
- Out-of-Area

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

** Closed to new enrollments.*

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

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

[3] Emergency room copay waived if admitted; waiver form available for certain circumstances: CareCompass.CT.gov.

[4] Prior authorization may be required.

[5] Subject to medical necessity review.

Using Your Benefits

In addition to the programs and tools described on **page 10**, you can use these options to maximize your benefits and get help making important health care decisions. **It doesn't matter which medical plan you enroll in—you have access to all of these benefits regardless of your choice.**

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

Use the online **Providers of Distinction Search**, or speak with a Care Coordinator (833-740-3258) to search by procedure, provider or facility. Doctors, hospitals and provider groups that meet the highest patient care standards are designated "Providers of Distinction." Providers of Distinction members will coordinate your care throughout your entire treatment process, from evaluation through recovery. The best providers within this program are identified as Centers of Excellence.

Earn incentives

If you select a Provider of Distinction for a qualifying procedure, you can earn a cash reward! There are over 20 qualifying procedures, including:

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

To view a full list of procedures, visit **CareCompass.CT.gov/ProvidersofDistinction/#incentives**. **Note:** The amount of the reward varies by procedure and location.

When you need a lab…

You pay nothing—$0 copay—if you visit a preferred Site of Service provider. To find a Site of Service provider, contact Anthem, or **use the Find Care tool**.

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

When you're traveling…

Within the U.S.: You have access to doctors and hospitals across the country with the BlueCard® program. Contact a Care Coordinator at 833-740-3258 for help switching to the Out-of-Area plan.

Internationally: You have access to providers in nearly 200 countries with the Blue Cross Blue Shield Global Core® program.

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

When you can't make it to the doctor…

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 (**App Store** or **Google Play**). Spanish-speaking members can use Cuidado Médico through LiveHealth Online to schedule a video visit with a Spanish-speaking doctor, 7 a.m. to 11 p.m., seven days a week. Site 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.

When you're injured…

Your health plan has resources to help you through orthopedic injuries, from diagnosis to minor aches and pains, to surgery and recovery.

Get help diagnosing minor or lingering injuries through a virtual visit. Your provider will help create a rehab program you can do at home.

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

Additional Programs

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

- **Access to a Care Coordinator.** There is one number you need to call when you have a question about your health care. Care Coordinators can be reached at 833-740-3258 8:30 a.m.-10 p.m. ET, Mon.-Fri. or by scheduling a call or live chat in your Quantum benefits portal.
- **Health Benefits portal accessible on web and on an app.** Visit **carecompass.quantum-health.com** to see your your HEP status, claims information, and more. You may also download the free mobile app by searching for “MyQHealth” at the App Store or on Google Play. If you haven’t registered on the site, choose **Register Now** and follow the steps.
- **Monthly Online Well-being seminars.** 30-minute seminars led by Wellspark health professionals are offered every month. Anyone in the HEP Chronic Condition program can satisfy the education requirement by participating in the corresponding "Basics" seminar. To find the seminar schedule, login to your Quantum benefits portal, click My Health, then HEP Webinars. The schedule also gets emailed out.
- **Monthly Orthopedic Webinars.** Each month a member of the Upswing care team will highlight an interesting topic and review how Upswing can assist in your orthopedic needs.
- **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**.
- **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.
- **Provider of Distinction.** The state of Connecticut has identified high-quality doctors, hospitals, and medical groups as “Providers of Distinction.” By visiting one of these providers or locations, you will automatically earn a cash incentive. Learn more at: **https://carecompass.ct.gov/providersofdistinction**

Clinical Health Programs

Help Managing and Reversing Diabetes

Virta Health offers programs that help you to manage Type 1 or 2 Diabetes or reverse Type 2 Diabetes. In the virtual reversal program, members learn to eat their way to better health with personalized nutrition plans and support from medical providers, professional coaches, and digital health tools. In the management program, members are connected and supported with access to a diabetes health coach. They also receive free testing supplies and tips to manage their A1c.

Preventing Diabetes

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

| To learn more about these programs, visit **CareCompass.CT.gov/diabetes**.

Health Enhancement Program (HEP)

The Health Enhancement Program (HEP) encourages you to take an active role in your health by getting age-appropriate wellness exams and screenings. **Retirees in Groups 4, 5, 6 and 7, 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 22**, you'll qualify for lower monthly premiums and reduced copays. You also won't pay a deductible when you receive in-network care. It's your choice whether or not to participate in HEP, but there are many advantages to doing so.

How to Enroll

- **Current retirees:** Those enrolled in 2022 will automatically be re-enrolled for 2023/2024. If you are not currently participating in HEP, you can enroll during Open Enrollment. Form (CO-1314) is available at **CareCompass.CT.gov/forms**.
- **New retirees:** If you are a new retiree who was enrolled in HEP as an active employee when you retired, you do not have to enroll in HEP—your current HEP enrollment will continue. If you're not currently enrolled in HEP and would like to enroll, you must complete the HEP enrollment form when you make your benefit elections. The HEP enrollment form (CO-1314) is available at **CareCompass.CT.gov/forms** or by calling 860-702-3533. You will not have to meet HEP requirements until the first calendar year in which you are enrolled in coverage as of January 1. If you do not wish to participate in HEP, you can disenroll during Open Enrollment.

HEP Requirements

Save Big with HEP

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

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

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

Chronic Condition Requirements

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

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

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

2023 HEP Required Exams and Screenings

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 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	Starting at age 45: Colonoscopy every 10 years, annual FIT/FOBT to age 75, or Cologuard screening every 3 years	Colonoscopy every 10 years, annual FIT/FOBT to age 75, 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.*

Prescription Drug Coverage

Your prescription drug coverage is administered by CVS Caremark.

Prescription benefits are the same no matter which medical plan you choose. The amount you pay depends on whether your prescription is for a generic drug, a brand name drug listed on CVS Caremark's preferred drug list (the formulary), or a non-preferred brand name drug.

Here's what you'll pay for covered prescription drugs filled at a network pharmacy.

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

In-Network	Group 4			Group 5[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 automatically be filled 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.

  New! When you fill a prescription for a specialty drug, you will automatically be enrolled in a PrudentRx program that reduces your out-of-pocket cost to $0. You can choose to opt out of this program.

To view the Specialty Pharmacy Drug List, go to **CareCompass.CT.gov/state/pharmacy**.

Tips for Reducing Your Prescription Drug Costs

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

Dental Coverage

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

Need help choosing a dental plan?

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

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

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

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

Consider the DHMO plans

The DHMO network continues to grow! Be sure to check your provider's status at **stateofct.cigna.com**. Enrolling in a DHMO plan could help you save money.

What's the difference between the two DHMOs? 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.

Dental Coverage at a Glance

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

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

Cigna's Virtual Care Program

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

Health Enhancement Program (HEP)

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

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

In the DHMOs, you must use an in-network dentist, or your exam won't be covered at all.

Oral Health Integration Program

Anyone enrolled in a State of Connecticut dental plan is eligible for Cigna's Oral Health Integration Program (OHIP). OHIP provides 100% reimbursement of certain services if you are pregnant or have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation). More information can be found at **stateofct.cigna.com**.

Savings on Non-Covered Services

Many of the Basic and Enhanced plan Cigna PPO network dentists have agreed to offer their discounted fees to you and your covered dependents for non-covered services. These savings may also apply to services that would not be covered because you reached your annual benefit maximum or due to other plan limitations such as frequency, age or missing tooth limitations.

You must visit a network dentist to receive these discounts. And you should verify that the procedure is listed on the dentist's fee schedule before receiving treatment. You are responsible for paying the negotiated fee directly to the dentist.

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

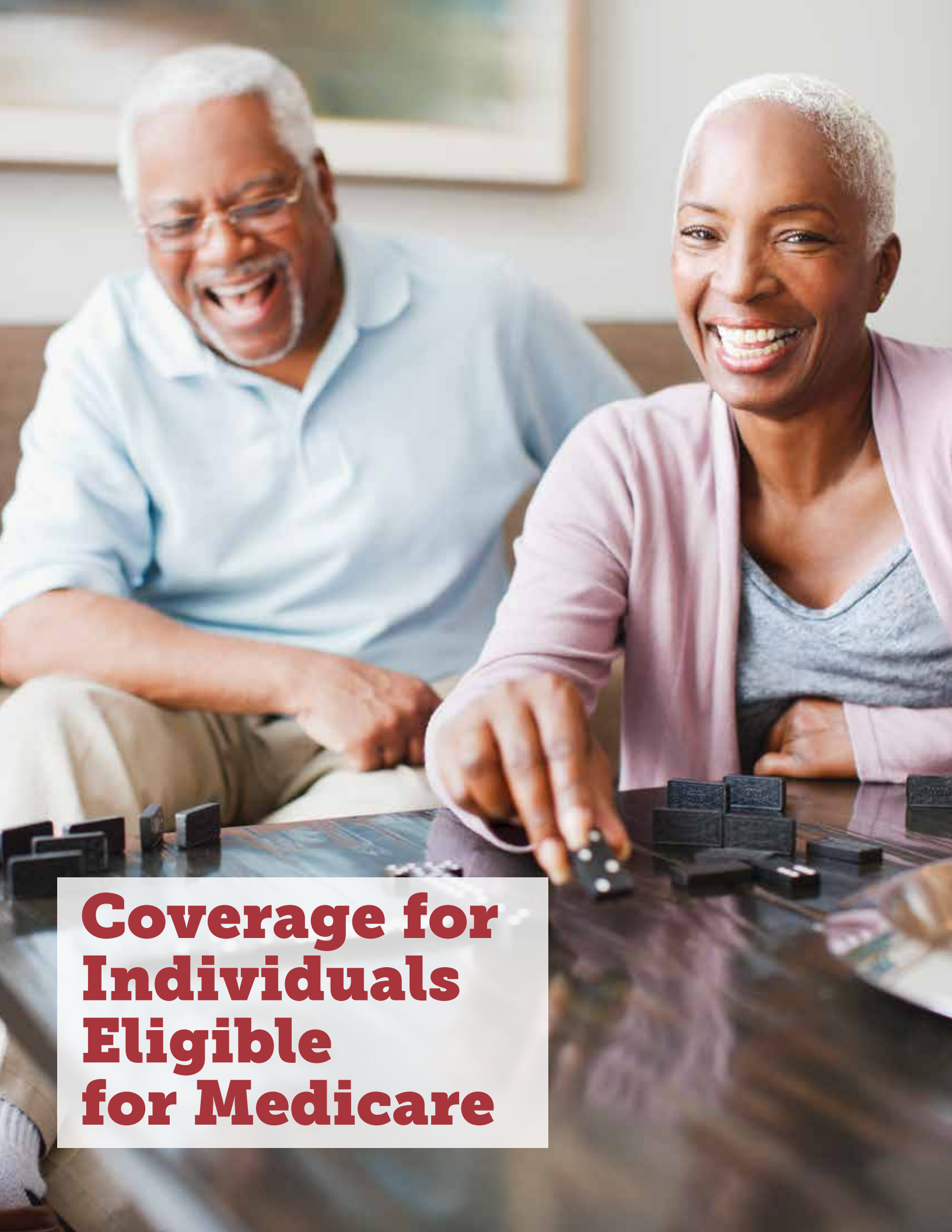
Pretreatment Estimates

Before starting extensive dental procedures where charges may exceed $200, your dentist may 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 at **CareCompass.CT.gov**.

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

myCigna Mobile App

Download the myCigna mobile app on the **App Store** or **Google Play** 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!



Coverage for Individuals Eligible for Medicare

Medicare and You

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

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

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

You May Be Missing Out on Additional Benefits

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

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

Medicare Part A and Part B

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

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

Once You Enroll in Medicare

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

Just before your 65th birthday, you will receive a letter from the Retiree Health Insurance Unit with more information about the Aetna Medicare Advantage PPO plan. Be sure to send the Retiree Health Insurance Unit a copy of your red, white and blue Medicare card. Your standard premium for Medicare Part B will be reimbursed by the state starting on the date a copy of your Medicare Part B card is received by the Retiree Health Insurance Unit. If cards are submitted more than 60 days past their issued date, reimbursement will be prospective from the date of receipt. Medicare premiums paid before a copy of your card is received will not be reimbursed. For 2023, the standard Medicare Part B/Part D premium reimbursement is $164.90.

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

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

1. **The Aetna Medicare Advantage plan is your only option for state-sponsored medical and prescription drug coverage.** If you opt out of the Aetna plan, you opt out of your state-sponsored coverage. Aetna is required by Medicare to inform you of the chance to opt out or cancel your enrollment. However, if you opt out, medical and prescription drug coverage and Medicare premium reimbursements for you and your dependents will terminate. **If you wish to continue state-sponsored health coverage, please ignore the opt-out information.**
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 Aetna Medicare Advantage plan includes Medicare Part D prescription drug coverage. **Enrolling in any other Medicare Advantage or Medicare Part D plan will disenroll you from the Aetna Medicare Advantage plan and cause your state-sponsored medical and pharmacy coverage to end for you and your dependents.**
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 Aetna Medicare Advantage PPO plan. Medicare Advantage plans (also known as Medicare Part C) combine all the benefits of Medicare Part A (hospital coverage) and Medicare Part B (medical coverage) into one plan and can also be combined with Medicare Part D (prescription drug coverage) to become one comprehensive hospital, medical and prescription drug plan. Medicare Advantage plans are offered by private insurance companies like Aetna.

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

How the Plan Works

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

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

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

Medical Coverage at a Glance

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

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 or later

Benefit Features	Aetna 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	$125
Diagnostic radiology services (e.g., MRIs, CT scans)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Lab services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient x-rays	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient hospital care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Skilled nursing facility (SNF)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient surgery	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient rehabilitation (physical, occupational or speech/language therapy)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Therapeutic radiology services (such as radiation treatment for cancer)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%

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

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

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

Aetna Additional Programs

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

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

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

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

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

Qualifying participants who are eligible to perform the program activities may earn rewards by completing all or some of the program activities. Rewards will be distributed to participants in the form of a gift card. Rewards for 2023 cannot be earned after 12/31/2023, which is the expiration date of the program. Participants should check the terms of their Evidence of Coverage (EOC) prior to participating in any program activities. Except as set forth in the EOC, Aetna shall not be responsible for any costs associated with, or arising from, a participant's performance of program activities. Your participation in the Your Healthy Rewards program is voluntary and does not affect your benefits from your Aetna health plan. Eligibility is limited to the Aetna member that this communication was addressed to. Subject to benefits and eligibility verification.

Prescription Drug Coverage

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

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

Prescription Drug Coverage at a Glance

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

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

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

Prescription Drug Tiers

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

Prior Authorization

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

Tips for Reducing Your Prescription Drug Costs

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

Dental Coverage

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

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

Need help choosing a dental plan?

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

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

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

Consider the DHMO plans

The DHMO network continues to grow! Be sure to check your provider's status at **stateofct.cigna.com**. Enrolling in a DHMO plan could help you save money.

What's the difference between the two DHMOs? 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.

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

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

Dental Coverage at a Glance

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

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

Oral Health Integration Program

Anyone enrolled in a State of Connecticut dental plan is eligible for Cigna's Oral Health Integration Program (OHIP). OHIP provides 100% reimbursement of certain services if you are pregnant or have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation). More information can be found at **stateofct.cigna.com**.

Savings on Non-Covered Services

Many of the Basic and Enhanced plan Cigna PPO network dentists have agreed to offer their discounted fees to you and your covered dependents for non-covered services. These savings may also apply to services that would not be covered because you reached your annual benefit maximum or due to other plan limitations such as frequency, age or missing tooth limitations.

You must visit a network dentist to receive these discounts. And you should verify that the procedure is listed on the dentist's fee schedule before receiving treatment. You are responsible for paying the negotiated fee directly to the dentist.

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

Pretreatment Estimates

Before starting extensive dental procedures where charges may exceed $200, your dentist may 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 at **CareCompass.CT.gov**.

Cigna's Virtual Care Program

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

myCigna Mobile App

Download the myCigna mobile app on the **App Store** or **Google Play** 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!

Frequently Asked Questions

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

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

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

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

- **Do retirees still have Medicare?**

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

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

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

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

  Yes, this plan offers nationwide coverage.

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

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

- **How are claims processed?**

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

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

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

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

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

Glossary

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

10 Things Retirees Should Know

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 **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 Aetna Medicare Advantage PPO plan, you do not need to use your red, white and blue Medicare card.** You should use your Aetna Medicare Advantage ID card for all covered medical and prescription drug needs. Put your Original Medicare card somewhere for safekeeping. It is important that you use your Aetna ID card each time you receive medical services or fill a prescription.
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 Aetna Medicare Advantage PPO plan. State health plan retirees and dependents who are not eligible for Medicare can choose from a variety of plan options, which do not include the Aetna Medicare Advantage plan. This means that some retirees and dependents may be enrolled in different plans. This is often referred to as a "split family."
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 Medicare Part A hospital insurance (which is premium-free) and Medicare Part B medical insurance (you pay the premiums).
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 Aetna Medicare Advantage PPO plan includes Medicare prescription drug coverage. If you enroll in a stand-alone Medicare Part D (Medicare prescription drug) plan, you may be disenrolled from this plan.
7. **Medicare-eligible members must pay premiums to the federal government.** You must continue to pay Medicare for your Part B and/or IRMAA related Part D premiums. Your standard premium for Medicare Part B is reimbursed by the state starting with the date your Medicare Part B card is received by the Retiree Health Insurance Unit. Cards and premium information submitted more than 60 days past their issued date will be reimbursed prospective from the date of receipt.
8. **Premiums for coverage must be paid, if applicable.** Premiums you must pay for non-Medicare-eligible health coverage or dental coverage will automatically be deducted from your monthly pension check. If your pension check is not enough to cover the premium amount, you must pay the balance to continue eligibility for coverage.
9. **You must disenroll ineligible dependents within 31 days after the date they become ineligible.** Find more information on qualifying status changes on **page 6**. If you continue to cover an ineligible dependent after the 31-day period, you may be charged a fine.
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 Retiree Health Insurance Unit	860-702-3533	**CareCompass.CT.gov**
Coverage for Non-Medicare-Eligible Individuals			
General benefit questions, Medical, and Health Enhancement Program (HEP)	Quantum Health	833-740-3258	**CareCompass.CT.gov** Or login to your benefits portal from Care Compass
Prescription drugs	CVS Caremark	800-318-2572	**CareCompass.CT.gov/state/pharmacy** Or login to your benefits portal from Care Compass
Dental	Cigna	800-244-6224	**CareCompass.CT.gov/state/dental** Or login to your benefits portal from Care Compass
Coverage for Medicare-Eligible Individuals			
Medical and prescription drugs	Aetna	1-855-648-0391 (TTY: 711), Monday to Friday, 8 AM to 9 PM ET.	**ct.aetnamedicare.com**
Dental	Cigna	800-244-6224	**CareCompass.CT.gov/retireedental**

RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744-OE REV. 1/2023

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

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**	**Home Telephone Number**

Email Address	**Cell/Mobile Telephone Number**

② Application Type

☐ New Retirement Enrollment	Qualifying Status Change:	Date of Event: ____/ ____/ _____
☐ Annual Open Enrollment	☐ Marriage	☐ Start of Other Coverage
☐ Adding/Dropping Dependents	☐ Birth/Adoption	☐ Loss of Other Coverage
	☐ Change in Dependent Eligibility Status	☐ 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.

☐ Primary Care Access [POE-G Plus]	☐ Expanded Access [POS]	☐ No Change – Keep Current Medical Benefit Plan
☐ Standard Access [POE]	☐ Anthem State Preferred POS – **Currently Enrolled Only**	
☐ Quality First Select Access [Prime Plus/Tiered POS] **new**	☐ Anthem Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**	☐ Waive/Cancel Medical and Prescription Coverage

⑤ Choose Your Dental Plan

☐ Basic Dental Plan ☐ Enhanced Dental Plan ☐ Total Care DHMO Plan ☐ Cigna 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**

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

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

CARE COMPASS

CareCompass.CT.gov

April 2023