Dental Plan Coverage:

Plan year July 1, 2024-June 30, 2025

CARE COMPASS **Non-Medicare Retirees**

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. 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 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.*

	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[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.

Medical Plan Coverage:

Plan year July 1, 2024-June 30, 2025

CARE COMPASS **Non-Medicare Retirees**

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

Here's how much you pay for covered services depending on where you choose to receive care. You (and your covered dependents) must live in Connecticut to select this plan.

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

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

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

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

Medical Plan Coverage:

Plan year July 1, 2024-June 30, 2025

CARE COMPASS **Non-Medicare Retirees**

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

** 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/forms**.

[3] Prior authorization may be required.

[4] Subject to medical necessity review.

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

Medical Plan Coverage:

Plan year July 1, 2024-June 30, 2025

CARE COMPASS **Non-Medicare Retirees**

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

** Closed to new enrollments.*

[3] Prior authorization may be required.

[6] Waived for HEP-compliant members.

Medical Plan Coverage:

Plan year July 1, 2024-June 30, 2025

Non-Medicare Retirees

Out-of-Network

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

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

** 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/forms**.

[4] Prior authorization may be required.

[5] Subject to medical necessity review.

Prescription Drug Coverage:

Plan year July 1, 2024-June 30, 2025

CARE COMPASS **Non-Medicare Retirees**

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

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

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

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

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