FREQUENTLY ASKED QUESTIONS
OPEN ENROLLMENT

May 1-31, 2024 • Open Enrollment for Plan Year 2024-2025

ENROLLMENT

WHAT IS OPEN ENROLLMENT?

Open Enrollment is your annual opportunity to make changes to your Anthem medical and Cigna dental coverage, including changing plans and adding or removing dependents. You cannot make any changes during the plan year unless you have a qualifying life event.

WHICH PLAN IS BEST FOR ME? WHAT ARE THE COSTS?

The Care Compass Benefits Enrollment page has plan comparison tools, plan comparison charts and bi-weekly plan rates.

I DON'T KNOW WHAT PLANS I AM ENROLLED IN. HOW CAN I FIND OUT?

Your Anthem and Cigna cards list your plan names.

HOW DO I MAKE A CHANGE (I.E. ADD A DEPENDENT OR CHANGE A PLAN)?

If you want to make a change to your coverage for 2024/2025, retirees should complete the CO-744OE Enrollment Change form mailed to you, or find it on carecompass.CT.gov/forms.

WHAT HAPPENS IF I DON'T DO ANYTHING DURING OPEN ENROLLMENT?

You will remain enrolled in the same plans with the applicable 2024/2025 premiums.

OUT-OF-STATE COVERAGE

DOES MY PLAN COVER MY CHILD WHO IS ATTENDING COLLEGE OUT OF STATE?

Anthem has an Away From Home Care (AFHC) program that connects your dependent with a local PCP to coordinate health care while away from home.

- If you are enrolled in the Primary Care Access (POE Plus) plan or the Quality First Select Access plan and your dependent is living out of state for 90 consecutive days or more, it may be best for your dependent to enroll in the AFHC program. You will need to contact Quantum at 833-740-3258 to enroll and disenroll from the AFHC program.
- If you are enrolled in the Standard Access (POE), Expanded Access (POS) and State Preferred plans, you have national access in which your dependent can locate participating providers in each of the 50 states and in Puerto Rico.

WHAT PLAN SHOULD I ENROLL IN IF I LIVE ON THE CT BORDER?

If you live in Connecticut, Rhode Island or Massachusetts, you can enroll in any of the plans, however:

- If you choose the Primary Care Access (POE Plus) plan, your primary care doctor must be based in Connecticut or in Anthem's service area, which may include some providers in Massachusetts, Rhode Island or possibly New York.
- For the Quality First Select Access plan, choose providers who are in Connecticut to avoid out-of-network coinsurance and deductibles.

WHAT IF I HAVE A MEDICAL EMERGENCY WHEN I AM OUT OF STATE?

Medical emergencies are covered in or out of network. Out-of-network claims must be paid out of pocket and submitted to Anthem for reimbursement. The $250 copay for an emergency room visit is waived if you are admitted.

AM I COVERED IF I AM VACATIONING OUTSIDE OF THE U.S.?

You have access to a worldwide network of providers in nearly 200 countries with BlueCross Blue Shield Global Core Program.

DENTAL PLAN

WHAT IF MY DENTIST TELLS ME THEY ARE NO LONGER ACCEPTING MY INSURANCE?

For Enhanced and the two DHMO plans, you will be covered for the remainder of the plan year, which is June 30th, However, if you've received a notice from Cigna that your provider is leaving your plan's network, then you will need to choose a new in-network provider for the new plan year (July 1, 2025) or change to a plan that your current provider is in-network during this open enrollment.

WHICH PLAN IS BEST FOR ORTHODONTICS?

The Enhanced plan and both Dental Care DHMO and Total Care DHMO plans cover orthodontia services. The Enhanced plan will allow coverage up to a $1500 lifetime maximum per person whereas DHMO plans will cover up to a maximum of 24 months of treatment. The Dental Match Quiz can help with cost comparison.

WHEN IS THE ANNUAL DEDUCTIBLE CHARGED FOR THE ENHANCED PLAN?

The annual deductible is $25 for an individual plan and $75 for the family plan; if the coverage is emp + 1, the maximum deductible is $50. The deductible resets on the calendar year (January 1st) and the benefit schedule also runs on a calendar year (ex – 2 cleanings covered per calendar year). The deductible does NOT apply to Class 1 services (preventive and diagnostic OR periodontal maintenance). The deductible would be charged by your provider for services like fillings, crowns, orthodontia, etc.

HEALTH ENHANCEMENT PROGRAM (HEP)

HOW DO I FIND OUT IF I AM HEP COMPLIANT?

Log in to your benefits/HEP portal then click the My Health tab. For assistance from your benefits portal, chat or send a secure message to your Quantum Health Care Coordinators or call (833)740-3258.

HOW DO I VIEW MY DEPENDENT'S HEP COMPLIANCE STATUS?

Dependents 18 and under will be listed under the primary account holder's Overview page. Adult dependents (18 or older) need to create their own Quantum Health account, then can go to Profile Settings, select Privacy Authorization and check the box next to Wellness/Prevention in order to see outstanding items.

HOW DO I OPT INTO HEP? HOW DO I OPT OUT OF HEP?

If you are enrolling in benefits for the first time, you will automatically be enrolled in HEP. To opt out, submit Form CO-1316 (Found on carecompass.ct.gov/forms) to your agency benefits office during open enrollment or the first 31 days of hire.

QUANTUM HEALTH BENEFITS/HEP PORTAL

WHAT DO I NEED TO REGISTER FOR THE PORTAL?

Register using the last four digits of your Anthem medical ID number and your name as it appears on your card. If you have recently enrolled in medical benefits, you will need to wait to receive your Anthem medical ID card to ensure you are in the system. You will also need an email address to confirm your account.

WHO CAN REGISTER FOR THE BENEFITS PORTAL?

Retirees enrolled in the Anthem medical plan, and their enrolled spouses and adult dependents.

I HAVE HAD A NAME CHANGE RECENTLY. WHAT DO I NEED TO DO?

Check with your agency's benefits specialist to make sure your information is correct on Core-CT.

WHAT IS A CARE COORDINATOR? WHAT CAN THEY HELP ME WITH?

Visit CareCompass.CT.gov/care-coordinators to learn how to contact a Care Coordinator and ways they can assist you with your benefits.

RETIREE COVERAGE

WHEN I TURN 65 AND IF I AM ENROLLED IN MEDICAL BENEFITS...DO I ALSO HAVE TO PAY MEDICARE FEES?

You do not. Medicare Part A is free of charge, so no harm in accepting enrollment in Part A hospital benefits, but you aren't likely to have coverage needs on Medicare.

MEDICARE-ELIGIBLE DEPENDENTS

As an active employee, you may add your Medicare-eligible dependent to your health coverage during Open Enrollment, however, in most cases, it is not recommended. While you are an active employee, your Anthem coverage will be their primary coverage. If enrolled in Medicare Part B as well, you may incur an additional premium and risk claims not being paid due to required coverage coordination.

I AM RETIRED AND TURNING 65 IN A FEW MONTHS, WHEN DO I ENROLL IN MEDICAL ADVANTAGE PLAN?

As a State of Connecticut Retiree Health Plan member, when you reach age 65, you must enroll in Medicare Parts A and B. A few months before your 65th birthday, you will receive a letter from the Retiree Health Insurance Unit reminding you to enroll in Medicare and informing you about our Aetna Medicare Advantage PPO plan.

More questions? Try out our automated Q&A feature on Care Compass! Simply click the Benefits Search button at CareCompass.CT.gov.