State Employee

FREQUENTLY ASKED QUESTIONS
OPEN ENROLLMENT

May 1-31, 2025 • Open Enrollment for Plan Year 2025-2026

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, like getting married.

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. Also, you can log in to CORE-CT, and select Self-Service > Benefit Details > Benefits Summary. To view your enrolled dependents, click on the options under the Type of Benefit header.

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 2025/2026, log in to CORE-CT and select Self-Service > Benefits > Benefits Enrollment. If you do not have access to CORE-CT, contact your agency's benefits specialist.

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

You will remain enrolled in the same plans with the applicable 2025/2026 premiums.

WHEN IS MY COVERAGE ACTIVE?

Your coverage begins the first day of the month that follow your hire date.

WHEN WILL I GET MY MEMBERSHIP ID?

You should have the card within 7-10 business days of processing. You can also call a Care Coordinator at 1-833-740-3258, and they may be able to provide you with the number over the phone and show you how to download digital cards.

MEDICAL PLAN

WHAT IS NEW WITH THE QUALITY FIRST SELECT ACCESS PLAN?

The plan's Connecticut-based network has expanded to include Hartford Healthcare providers and facilities. Those enrolling in the plan for the first time this plan year will have slightly increased premiums compared to current rates.

WHO IS ELIGIBLE TO ENROLL IN THE QUALITY FIRST SELECT ACCESS PLAN?

To enroll in this plan, you and any covered dependents must reside in Connecticut. Residency is subject to audit.

WITH FOUR PLANS TO CHOOSE FROM, HOW DO I KNOW WHICH ONE IS BEST?

All four plans offer the same medical coverage. The difference lies in how you access care. You need to consider provider network size, primary care referral requirements, out of network coverage and premiums. For help, take the medical plan decision quiz on Care Compass.

WHO DETERMINES IF A PROVIDER IS IN-NETWORK OR OUT-OF-NETWORK?

While the Care Compass Find Provider tool shows only in-network providers (by selected plan), you should contact your provider directly to confirm their status. Your provider negotiates their status with the carrier directly. If a provider is in-network, then the provider has agreed to be paid at in-network network rates. Provider status can change outside our open enrollment period because these are privately negotiated between the provider and the insurance carrier.

DENTAL PLAN

WHAT CHANGES ARE BEING MADE TO THE DENTAL CARE DHMO PLAN?

The Dental Care DHMO plan is now closed to new enrollments. Current members can stay enrolled or choose to switch plans. The Total Care DHMO plan, which uses the same provider network, offers better benefits and lower out-of-pocket costs.

ARE THERE ANY CHANGES TO THE OTHER DENTAL PLANS?

Yes, both the Enhanced and Basic dental plans will have slight coverage adjustments for the new plan year; especially for out-of-network care. Review the plan comparisons and take the Dental Plan Match Quiz to see what plan works best for you.

WHICH PLAN IS BEST FOR ORTHODONTICS?

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

HOW DO I KNOW IF MY DENTIST IS IN-NETWORK FOR MY PLAN?

It's easy to confirm online using the Find a Dentist lookup tool or call Cigna at 800-244-6224.

SUPPLEMENTAL BENEFITS

CAN I ENROLL IN SUPPLEMENTAL BENEFITS, LIKE LIFE INSURANCE, DURING OPEN ENROLLMENT?

The annual Open Enrollment period is for health benefits only. You can enroll in life insurance as a new hire or at any time with proof of insurability. Flexible Spending Accounts (FSAs) have a separate Open Enrollment period each October. For details on all supplemental benefits and their enrollment timelines, visit carecompass.ct.gov/supplemental-benefits.

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.

Stay Connected: Update Your Home Address Today! Please confirm with your HR that your correct mailing address and contact information are on file so you don't miss out on important communications.

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

The Primary Care Access, Standard Access, Expanded Access are options. If you live in a bordering state, please note:

- 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.
- The Quality First Select Access plan is only for Connecticut residents.

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

Medical emergencies are covered in or out of network in all plans. 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. Form CO-1350 must be submitted for refund.

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. Contact a Care Coordinator for assistance.

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. If you are enrolled and wish to opt-out, you can do so only if you are are HEP compliant.

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?

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

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

Login to CORE-CT>Personal Details>Addresses, or 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.

HAVE MORE QUESTIONS?

Care Coordinators are standing by to answer your benefits-related questions. They are trained to help you understand all of your benefits and to coordinate between all programs and partners. Your benefit needs are personal, the support you and your family get should be personal too.

PHONE: 833-740-3258 **WEBSITE:** carecompass.ct.gov > Benefits Login (secure messaging once logged-in)