



FOR STATE OF CONNECTICUT
RETIREES

Retirement Date Prior to July 1997





A Message from the State Comptroller

Your choices make a difference. Every day you make decisions about your health and your healthcare – you walk instead of drive, you have the salad instead of the fries, you get regular checkups and dental care.

What you do every day not only affects your health and what you pay out of pocket for your healthcare, it has an impact on how taxpayer dollars are spent and what's left for other important programs. Even if you're happy with your current coverage, it's a good idea to review the plans each year. All of the medical plans cover the same services – the differences are in which providers are in each network, how you access care, and how each plan helps you manage your family's health.

This year, all carriers offer national provider networks. You may be able to change your plan and keep seeing the same doctors.

Please take a few minutes now to consider your options and choose the best value for you and your family. Everyone wins when you make smart choices about your health and your healthcare.

Nancy Wyman
State Comptroller
May 2008

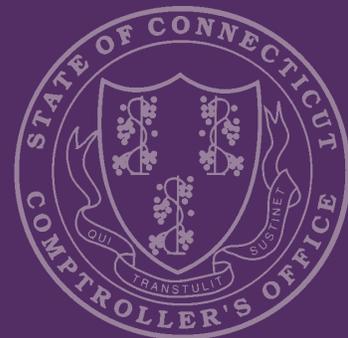


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What You Need to Do

Choose Carefully

Once you choose your medical and dental plans, you cannot make changes during the plan year (July 1 – June 30) unless you experience a qualifying status change. If you do have a qualifying status change, you must notify the Retirement Health Insurance Unit within 31 days of the event. The change you make must be consistent with your change in status – for example, if you get divorced, you must drop your spouse from coverage.

Please call the Retirement Health Insurance Unit if you experience a qualifying status change – they include changes in:

- **Legal marital/civil union status** – Any event that changes your legal marital/civil union status, including marriage, civil union, divorce, death of a spouse and legal separation.
- **Domestic partnership status** – You enter into or end a domestic partnership.
- **Number of dependents** – Any event that changes your number of dependents, including birth, death, adoption and legal guardianship.
- **Employment status** – Any event that changes your, your spouse/domestic partner's or another dependent's employment status, resulting in gaining or losing eligibility for coverage such as:
 - Beginning or ending employment
 - Starting or returning from an unpaid leave of absence
 - Changing from part time to full time or vice versa.
- **Dependent status** – Any event that causes your dependent to become eligible or ineligible for coverage because of age, student status, status as an IRS dependent or similar circumstances. Except for disabled dependents, dental coverage ends at age 19 and medical coverage ends at age 23 (dependent must be a full-time student to continue medical coverage from age 19 to 23).
- **Residence** – A significant change in your place of residence that affects your ability to access network providers.

If you experience a change in your life that affects your benefits, contact the Retirement Health Insurance Unit. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).

Retirees and dependents eligible for Medicare Part A (Hospital Insurance) must enroll in Medicare Part B (Medical Insurance), regardless of age. Your Medicare Part B premium will be reimbursed by the State effective from the date your Medicare Part B card is received by the Retirement Health Insurance Unit. (Medicare premiums paid before your card is received will not be reimbursed.)

Open Enrollment Is May 19 – June 13, 2008

Every spring during open enrollment, you have the opportunity to adjust your healthcare benefit choices. It's a good time to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best value. For 2008 Open Enrollment Information, please go to the Comptroller's website at <http://www.osc.state.ct.us> or check with the Retirement Health Insurance Unit.

During open enrollment, you may change medical and/or dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage.

Complete and return the form in the back of this booklet if you'd like to make a change for 2008-2009. The form must be postmarked by June 13, 2008. Any changes you make are effective July 1, 2008 through June 30, 2009 unless you have a qualifying status change. If you don't want to make changes, you don't need to do a thing, your current coverage will continue automatically at the new rates listed on page 21.

Return completed enrollment forms to:

Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106

Your Medical Plans at a Glance

BENEFIT FEATURES	ALL CARRIERS	ALL CARRIERS
	POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	POS OUT OF-NETWORK
Annual Deductible		
Each Individual	None	\$300
Family (3 or more)	None	\$900
Annual Out-of-Pocket Maximums		
Each Individual	None	\$2,000 (plus deductible)
Family	None	\$4,000 (plus deductible)
Coinsurance	None	You pay 20% of allowable charge plus*
Lifetime Maximum	None	None
Outpatient Physician Visits	\$5 copay	80%
Preventive Care		
Children	No copayment for well-child visits and immunizations	80%
Adults	\$5 copay	
Family Planning		
Oral Contraceptives- Rx plan	Covered on same basis as other prescription drugs	Covered on same basis as other prescription drugs
Vasectomy	100% (pre-certification required)	80% (pre-certification required)
Tubal Ligation	100% (pre-certification required)	80% (pre-certification required)
Inpatient Physician	100% (pre-certification required)	80% (pre-certification required)
Inpatient Hospital	100% (pre-certification required)	80% (pre-certification required)
Outpatient Surgical Facility	100% (pre-certification required)	80% (pre-certification required)
Ambulance	100% (if emergency)	100% (if emergency)
Pre-admission Certification/ Concurrent Review	Through participating provider	Penalty of 20% up to \$500 for no certification
Mental Health	Pre-certification required	Pre-certification required
Inpatient	100%	80%
Outpatient	\$5 copay	80%
Substance Abuse	Pre-certification required	Pre-certification required
Detoxification	100%	80%
Inpatient	100%	80%
Outpatient	\$5 copay	80%
Skilled Nursing Facility	100% (pre-certification required)	80%, up to 60 days/year (pre-certification required)
Home Health Care	100% (pre-certification required)	80%, up to 200 visits/year (pre-certification required)
Hospice	100% (pre-certification required)	80%, up to 60 days (pre-certification required)
Short Term Rehabilitation and Physical Therapy	100%	80%, up to 60 inpatient days, 30 outpatient days per condition per year
Diagnostic X-Ray and Lab	100%	80%
Pre-Admission Testing	100%	80%
Urgent or Emergency Care	100%	100%
Durable Medical Equipment	100% (pre-certification required)	80% (pre-certification required)
Prosthetics	100% (pre-certification required)	80% (pre-certification required)
Routine Eye Exam	\$15 copay, 1 exam per year	50%, 1 exam every 2 years
Audiological Screening	\$15 copay, 1 exam per year	80%, 1 exam per year

* You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

More details about covered expenses are available from the plans. (See Your Benefit Resources on page 26.)

What's New for 2008-2009

Money-Saving Tip

Do you take any prescriptions on an ongoing basis (for example, high-blood pressure medication)? Did you know that you can save time and money by picking up a 3-month supply of maintenance prescription drugs at the pharmacy?

When you fill your prescription for up to a 3-month supply (instead of 34 days), you pay only 1 copay instead of 3 – plus you make only 1 trip to the pharmacy, instead of 3.

Expanded Provider Networks

If you need access to a national provider network (other than for emergencies), you now have more options. Effective July 1, all State of Connecticut plans offer access to network providers across the country – particularly helpful if you are planning to live or travel out of the region.

New Carrier for Dental HMO

The dental HMO will be offered through CIGNA effective July 1. If you are enrolled in the Aetna DMO, see page 19 for how this change may affect you.

Making Your Decision

Each of the medical plans offered by the State of Connecticut is designed to cover the same expenses – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. (See page 3 for a side-by-side comparison.) How do you decide?

When it comes to choosing a medical plan, there are four main areas to look at:

1. What is covered – the services and supplies that are covered expenses under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 3.)
2. Cost – what you pay at the time you receive services is similar across the plans (see the chart on page 3).
3. Networks – whether your doctor or hospital have contracted with the plan. (See pages 5 and 6.)
4. Plan features – how you access care and what kinds of “extras” the plan offers. Under some plans you must use network providers except in emergencies, others give you access to out-of-network providers. Finally, you may prefer one company over another (see pages 7-13).

The following pages are designed to help you compare your options.

For 2008 Open Enrollment information

Please go to the Comptroller's website at <http://www.osc.state.ct.us> or check with the Retirement Health Insurance Unit.

Comparing Networks

When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you're like many people, you made a choice when you first retired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs.

Many doctors belong to multiple provider networks. And, over the last few years, all of the plans have made significant improvements to their provider networks. Now is the time to check to see if your doctor is a network provider under more than one of the plan options. Then, take a fresh look at your options.

Why Networks Matter

All of the plans cover the same healthcare services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Each plan contracts with a group of doctors and hospitals for discounted rates on healthcare services. Getting your care within the network provides the highest benefit level:

- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – but, you'll pay more for out-of-network services.

Is a National Network Important to You?

All State of Connecticut plans have a national provider network. That means they contract with doctors and hospitals across the country – and you have nationwide access to the highest level of benefits.

- Planning to live or travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that's not in Connecticut or in the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. All plans have a national network available in 2008 – 2009. Check to see if you might have access to doctors and hospitals across the country even when you choose a POE or POE-G plan. And, if you choose a POS plan, you have nationwide options for care at in-network benefit levels. Take a look at your options before you decide.



How the Plans Work

Point of Service (POS) Plans – These plans offer healthcare services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Healthcare services obtained outside the network may require preauthorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

Point of Enrollment (POE) Plans – These plans offer healthcare services only from a defined network of providers. (Out-of-network care is covered in emergencies.) No referrals are necessary to receive care from in-network providers. Healthcare services obtained outside the network may not be covered.

Point of Enrollment – Gatekeeper (POE-G) Plans – These plans offer healthcare services only from a defined network of providers. (Out-of-network care is covered in emergencies.) You must select a primary care physician (PCP) to coordinate all care and referrals are required for all specialist services.

Using Out-of-Network Providers

When you enroll in one of the State of Connecticut POS plans, you can choose a network or out-of-network provider each time you receive care. When you use an out-of-network provider, you'll pay more – for most services, the plan pays 80% of the allowable charge after you pay your annual deductible. Plus, you pay 100% of the amount your provider bills above the allowable charge.

In the POS plans there are no referral or preauthorization requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, it's a good idea to call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live Affects Your Choices

You must live within a plan's regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the Health Net Charter Plan, you must live within the Health Net regional provider network. If you live outside that area, you should choose one of the out-of-area plans. Both plans give you access to a national provider network.



Comparing Plan Features

All State of Connecticut plans cover the same healthcare services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency), some give you access to out-of-network providers when you pay more of the fees, some require you to select a PCP.
- **Health promotion** – Remember, there’s more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.
- **Provider networks** – You’ll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 26 for phone numbers and websites.)
- **Discounts** – All plans offer discounts to members for certain health-related expenses such as gym memberships and eyeglasses.

About Value-Added Programs

Another area where the plans may differ is the value-added programs they offer. These programs are outside the contracted plan benefits – they’re “extras” that each company offers in hopes of making their plan stand out, such as:

- Member discounts (for example, on weight-loss programs or health clubs)
- Wellness programs
- Online health promotion programs

Because these value-added programs are not plan benefits, they are subject to change at any time by the health plan. However, you may want to see what each plan offers before you decide.

	POINT OF ENROLLMENT GATEKEEPER (POE-G) PLANS			POINT OF ENROLLMENT (POE) PLANS			POINT OF SERVICE (POS) PLANS				OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	Health Net Passport HMO	UnitedHealthcare Oxford HMO	Anthem State BlueCare	Health Net Charter HMO	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS	Health Net Charter	UnitedHealthcare Oxford Freedom Select	Anthem State Preferred OOA	UnitedHealthcare Oxford USA
National network	X	X	X	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available							X	X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X	X	X						
No referrals required for care from in-network providers				X	X	X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X	X									

Comparing Plans: A Message From Anthem

Anthem Blue Cross and Blue Shield Offerings



Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

STATE BlueCare POE Plus

In-Network Benefits

- \$5 office visit copay
- Referral needed to see a specialist
- Annual physical and routine eye exam
- Over 16,000 Connecticut and 745,000 national providers are in the network
- All Connecticut general hospitals and over 6,000 hospitals nationally are in the network
- Quest – the largest laboratory network in Connecticut – is in the network
- **NEW** – National access.

STATE BlueCare POS

In/Out-of-Network Benefits

- \$5 office visit copay
- Annual physical and routine eye exam
- Over 16,000 Connecticut and 745,000 national providers are in the network
- All Connecticut general hospitals and over 6,000 hospitals nationally are in the network
- Quest – the largest laboratory network in Connecticut – is in the network
- **NEW** – National access.

STATE BlueCare POE

In-Network Benefits

- \$5 office visit copay
- Annual physical and routine eye exam
- Over 16,000 Connecticut and 745,000 national providers are in the network
- All Connecticut general hospitals and over 6,000 hospitals nationally are in the network
- Quest – the largest laboratory network in Connecticut – is in the network
- **NEW** – National access.

STATE Preferred POS

In/Out-of-Network Benefits

- \$5 office visit copay
- Annual physical and routine eye exam
- Over 17,000 Connecticut and 727,500 national providers are in the network.
- All Connecticut general hospitals and over 6,000 hospitals nationally are in the network
- Quest – the largest laboratory network in Connecticut – is in the network
- National and international network

You can continue to access a Guest Membership through our Away From Home Care coverage. This option is available to give you flexibility and ease when accessing your benefits.

State BlueCare POS, State BlueCare POE and State BlueCare POE Plus now feature national access. State of Connecticut employees and retirees can now choose any of the State BlueCare health plans. Massachusetts and Rhode Island residents can now enroll in any State BlueCare plan and select a Primary Care Physician, just as Connecticut residents have always been able to do.

To find a provider, call 1-800-810-BLUE (2583) or visit our website at anthem.com/statect > find a doctor > search national BlueCard directory > next > enter prefix identification > next > enter address or select by county > next > select a provider type > view results.

Because of this new national access feature, all State BlueCare members will be receiving new ID cards.

Every day, we're strengthening our commitment to you with our unique value-added programs designed to support and guide you through your health care decisions.

Vision

Eye Exams

Your State of Connecticut health benefits cover you for an annual routine eye exam. No matter which plan you have, you do not need a referral.

Value-Added Discounts

- **EyeMed** - Save 30% on eyeglasses, 25% on non-prescription sunglasses and enjoy discounted prices on exams. Choose from private practitioners or leading optical retailers including LensCrafters®, Target® Optical and most Sears Optical and Pearle Vision® locations.
- **TruVision™** - Pay just \$895 to \$1,895 per eye on LASIK laser vision correction or receive discounts of 15-20% and free shipping on contact lens orders.

SpecialOffers@AnthemSM

As a State employee or retiree, you can access discounts on all kinds of healthy living products and services by visiting anthem.com/statect > SpecialOffers@Anthem. These are just a few of the discounts available:

- Fitness club memberships, fitness equipment, coaching
- Weight Watchers®, Jenny Craig®
- Vitamins, supplements and wellness products

- Hearing aids
- Allergy products
- Baby/Maternity products and supplies
- Senior Care products

All of the offerings in the SpecialOffers@Anthem program are continually being evaluated and adjusted, so the offerings may change. Any additions or changes will be communicated on our website, anthem.com/statect. Discounts and services are not benefits under your Anthem health plan. Discounts may be revised or eliminated without notice at any time.

360° Health®

With our 360° Health® program, you get the information and services you need to live a healthier life and feel your best every day.

- **Health Resources** – Get info on wellness, health topics and specific conditions 24/7 online or through our Audio Tape Library and NurseLine
- **Health Extras** – Use interactive tools to learn more about staying healthy. Get discounts on healthy living products and services, including a smoking cessation program
- **Health Guidance** – Get support and guidance when you need it, 24/7, including the Future Moms maternity care program and Behavioral Health Advisors
- **Health Management** – Learn how to best manage a chronic illness or condition with Chronic Disease Management programs and the Neonatal Intensive Care Unit program

For more information, call our State-dedicated Member Services Unit at 1-800-922-2232 or visit our website at anthem.com/statect.

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Comparing Plans: A Message From Health Net



Health Net®
A Better Decision

New Network Providers!

- **Hospital for Special Surgery** – the number one orthopedic hospital in the country located in New York City with offices in Greenwich, Connecticut.
- **Hartford Medical Group** – 11 locations throughout Connecticut, several offices open seven days a week, specializing in Primary Care, Urgent Care, Gastroenterology, Occupational Medicine and Travel Medicine.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

For over ten years, Health Net has insured State of Connecticut employees and retirees. Being a Connecticut company ourselves, we are proud to be offered as an option to State of Connecticut employees. As a state employee, you are given the opportunity each spring to choose your health coverage for you and your family. This year, we encourage you to take another look at your options; a lot can change in a year.

We believe there are at least six reasons Health Net is more than “just another plan” and A Better Decision ...

- **Strong Regional Network** - Our Tri-State Advantage Platinum network includes every hospital in Connecticut, and over 148,000 provider office locations and 245 hospitals in New York, New Jersey and Connecticut.¹

We have also added some new best-in-class providers this year that State of Connecticut members have requested including:

- **Hospital for Special Surgery** - the number one orthopedic hospital in the country located in New York City with offices in Greenwich Connecticut.
- **Hartford Medical Group** - 11 locations throughout Connecticut, several offices open seven days a week, specializing in Primary Care, Urgent Care, Gastroenterology, Occupational Medicine and Travel Medicine.
- **New National Network** - at no additional cost to you! New this year, we offer quality physicians, facilities, and hospitals that give you excellent choice and access across all 50 states. (See the next page for details)

- **Decision-Making Tools and Wellness Resources** - to inform you, empower you and keep you healthy.
 - **Well Rewards program** offers discounts on products and services to help you take a proactive approach to your health.
 - **Online tools and resources** such as on-demand ID cards, claim status, prior authorization, hospital comparison report, treatment cost estimator, medication center, disease and conditions center, online physician and pharmacy search tool and much more.
- **Health Coaches** - Professional assistance, information and training that can assist you in making confident decisions about your health care, 24/7.
- **Member Advocates** - Dedicated State of Connecticut member-services line, staffed with highly-trained Member Advocates who live and work where you do, to support your service needs. You have questions. We have answers.
- **Quality Care Initiatives** - to help ensure the care you receive is safe and effective.
 - **National Committee for Quality Assurance** (NCQA) rating of “Excellent” for Health Net of Connecticut, New York and New Jersey-U.S.²
 - **U.S. News & World Report** recognized Health Net as one of the top-ten commercial health plans in the country³

¹ As of January 2008

² Accredited July 5, 2006 and valid until July 5, 2009

³ Listed in November 6, 2007 edition of U.S. News & World Report

...And if you look closer, you may find the difference between “just another health plan” and a partner who supports you and your family on your path to optimal wellness.

We understand these things. It’s what sets us apart. Our mission is to help people be healthy, secure and comfortable. We provide services that help individuals and families when they need them most, in ways that matter.

Please visit www.healthnet.com/stateofct for detailed 2008-2009 enrollment information. Or call our dedicated Member-Services Line for State of Connecticut employees and retirees at 1-800-255-5019.

National Network Access for State of Connecticut Members Enrolled with Health Net

Effective July 1, 2008, State of Connecticut health plan members enrolled with Health Net will be able to access in-network level benefits nationwide when seeking care outside of the service area. This new national network is available for all Health Net plans offered to State of Connecticut employees and retirees.

How does it work?

When seeing a physician in Connecticut, New Jersey or New York¹ (the Health Net service area), you use the Health Net Tri-State Advantage Platinum network. Our network includes approximately 148,000 physicians and providers and 245 hospitals in Connecticut, New Jersey and select counties in New York.^{1,2}

When outside our service area, but within the United States, you can use the national network (First Health) to receive covered services at the in-network level.³ The First Health national network is comprised of nearly 527,000 physicians and health care professionals, and 4,550 hospitals throughout the United States – making it easy to find and access services.^{2,3}

To find participating physicians or hospitals, visit the customized web site for State of Connecticut employees and retirees at www.healthnet.com/stateofct or, you may call the telephone number on the back of your Health Net ID card.

What are the benefits of a national network?

- No additional costs - same in-network copayments you pay today⁴
- No claim forms - simply present your Health Net ID card to any participating First Health provider (members are required to obtain prior authorization for specified services)
- No pre-registration necessary to obtain covered services from physicians outside our service area

Who benefits most from a national network⁵?

- Retirees who may reside elsewhere part of the year
- Students attending college outside of our service area
- Professors or teachers on sabbatical
- Those who travel for business

For more information, please call the State of Connecticut dedicated Member-Services Line at 1-800-255-5019 or visit www.healthnet.com/stateofct.

1. *The New York counties in our service area are the Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester counties.*
2. *As of January 2008.*
3. *National network provided by First Health, Inc. The First Health Network excludes coverage for Chiropractic, Acupuncture and Transplant coordination, which can be accessed while in the Health Net Service area.*
4. *For full coverage to apply, plan requirements regarding medical necessity and prior authorizations must be met. See your Evidence of Coverage (EOC) for additional details and requirements. Members must obtain Prior Authorization when required.*
5. *State of Connecticut Members who permanently reside and work outside of Health Net’s service area are not eligible for this program offering.*

Comparing Plans: A Message From UnitedHealthcare



Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Here's Why You Should Select an Oxford plan from UnitedHealthcare

With the lowest cost POS option (United Healthcare Oxford Freedom Select) and a national seamless network in all State of Connecticut plans, it's no wonder UnitedHealthcare, featuring State of Connecticut Oxford plans, is the fastest growing carrier choice for State of Connecticut employees. Every Oxford product plan provides access to our national network of 560,000 physicians and healthcare professionals¹ and our regional network in Connecticut, New York and New Jersey of over 74,000 providers². We provide access to over 220 hospitals nationwide – including all 32 hospitals in Connecticut.

Over the years we have been the only carrier to offer this kind of access to State of Connecticut employees, while keeping your cost shares low. Plus, State of Connecticut Retirees can enjoy the same access to quality care with our seamless nationwide network, so they can live and travel around the country without worry.

Three Steps to Quality, Affordable Health Coverage

- 1) Select an Oxford plan to meet your budget and your coverage needs**
 - We offer coverage options and plan designs that work for your personal and medical circumstances, at very affordable rates.
 - Oxford plans are among the lowest cost options of all plans offered to State of Connecticut employees.
- 2) Visit the Web site to search for a doctor**
 - **Log in** to www.oxfordhealth.com/stateofct, a **customized State of Connecticut Employee Web site**, and follow the directions to “Search for a Doctor”. To find doctors outside of New York, New Jersey or Connecticut, visit www.myuhc.com and click on the Find Physician or Facility link. Click on the “Search for a Physician” button. Be sure to choose “UnitedHealthcare Choice Plus” from the “Select a Plan” drop-down options.



- Members can also **search** for doctors identified under our **Premium® designation program** who meet or exceed evidenced-based performance standards for quality of care and cost-efficiency criteria. This user-friendly tool gives members access to information sorted by physician quality and cost-efficiency, enabling them to make informed decisions about where to get their care.

3) **Sign up now for access to our health discount programs!**

Our health discount programs complement your medical plan³ by offering savings on a wide range of health and wellness products and services for you and your family. From vision, dental and hearing care to health supplies and long-term care services, members get preferred rates.

- **Vision care savings** from a nationwide network of eye care professionals and facilities, as well as convenient online programs. Discount vision care savings include:

- 20% savings on eyeglass frames, lenses and options like tinting
- 10% to 20% savings on professional fees for contact lens fittings;
- LASIK and other vision correction surgeries at a 15% discount, plus more!

- **Healthy Bonus®** and **Health Allies** programs provide discounts and special offers **to help you to stay healthy while saving money** on weight loss programs, fitness products, nutrition products and publications, and more. All materials about these member discount programs, as well as other useful resources can be found by visiting www.oxfordhealth.com/stateofct.

When you select an Oxford plan from UnitedHealthcare you get a better value with more choices.

State of Connecticut Benefits Contact Information

Medical Coverage
Member Services (pre-enrollment)
1-800-760-4566

Member Services (post-enrollment)
1-800-385-9055
www.oxfordhealth.com/stateofct

Dental Coverage
Dedicated Service Center
1-800-896-4834
www.myuhcdental.com/statedct

¹ *UnitedHealthcare Choice Plus Network data as of December 2007.*

² *As of December 31, 2007, this data represents all participating providers except ancillary providers (i.e., laboratories, radiology centers, urgent care centers, etc.) and hospitals. Dental and complementary and alternative medicine providers are included. Providers who are board certified in more than one specialty are counted for each specialty. Therefore, providers who are board certified in more than one specialty are counted multiple times.*

³ *Offers are valid through December 31, 2008. Healthy Bonus and Health Allies offers are not insured benefits and are in addition to, and separate from, Oxford benefit coverage. These arrangements have been made for the benefit of members and do not represent an endorsement or guarantee on the part of the Oxford plan. Offers may change from time to time and without notice and are applicable to the items referenced only. Offers are subject to the terms and conditions imposed by the vendor. Oxford cannot assume any responsibility for the products or services provided by vendors or the failure of vendors referenced to make available discounts negotiated with Oxford: However any failure to receive offers should be reported to Customer Service by calling the number on your Oxford member ID card.*

Your Prescription Drug Coverage at a Glance

Your prescription drug coverage is through Caremark (formerly Pharmicare), no matter which medical plan you choose.

BENEFIT FEATURES	ALL MEDICAL PLANS
Prescription Drugs	
Network Retail Pharmacy*	\$3 generic/\$6 brand for up to 34-day supply Maintenance drugs 3-month supply – \$3 generic/\$6 brand
Mail-order Pharmacy	Maintenance drugs 3-month supply – \$3 generic/\$6 brand
Out-of-network Pharmacy	20% copay

*Over 59,000 pharmacies across the country

Special Information for Retirees in Out of Area Plans on Medicare

Effective July 1, 2008, plan members who are enrolled in Medicare and either the UnitedHealthcare Oxford USA or Anthem State Preferred Out of Area Plan no longer have different pharmacy benefits. Your pharmacy benefits are now the same as those for in-State retirees. Please review this page for details.

Important Note About Brand-Name Prescriptions

We encourage you to use generic drugs instead of brand-name drugs whenever possible. When you do, both you and the State save money. According to the FDA, generic drugs have the same active ingredients and are the same quality as their brand-name counterparts.

If you request a brand-name drug substitution, you pay the \$6 copay **plus** the difference between the cost of the generic and the brand name. If your physician feels that the brand-name drug is necessary and writes “dispense-as-written” or “no substitutes” on the prescription, you pay only the \$6 copay.

Save Time and Money with a 3-Month Supply

If you take maintenance medications, you can get a 3-month supply for 1 copay either through a network retail pharmacy or by mail:

NETWORK RETAIL PHARMACY	MAIL ORDER
<ul style="list-style-type: none"> • 3-month supplies of your medication • Face-to-face interaction with your pharmacist • Fewer trips to the pharmacy • Save 66% on your copays 	<ul style="list-style-type: none"> • 3-month supplies of your medication • Talk to a pharmacist by phone • Free, convenient home delivery • Save 66% on your copays • Easy enrollment and refill requests at www.caremark.com; 24 hours a day 7 days a week

Ask your doctor to write your prescription for a 3-month supply to start saving on your next prescription refill.

A Message From Caremark

Health Advocate Card

The look of the PharmaCare *Your Health Advocate Card* is changing. The card is now called the *CVS Caremark ExtraCare Health Card*. While the look and name are new, you will continue to enjoy a 20 percent discount on all CVS/pharmacy brand and propriety brand merchandise.

Beginning in March, new members requiring cards, as well as those who need replacement Health Advocate Cards, will receive the newly re-branded ExtraCare Health Card. Members with existing Your Health Advocate Cards do not need to have their card updated to continue to enjoy this benefit. Reminder – while the look and name will be new, all the features of the card remain the same, including the call center support number.

Health Risk Assessment (HRA)

In the coming months, Caremark will be offering a voluntary health risk assessment. It can help you determine if you are at risk for chronic conditions or, if you have a chronic condition, make lifestyle recommendations. In an effort to reduce health risks, this user-friendly tool enables you to:

- Assess your health status
- Evaluate individual risk factors
- Increase your personal readiness to make healthy changes.

Developed by the University of Michigan Health Management Resource Center, this health risk assessment (HRA) is backed by more than 20 years of research. The HRA can be used as part of your overall wellness strategy. We'll be sending you information about the program when it becomes available.

CAREMARK®

Value-added programs such as wellness programs and discounts offered by the prescription benefit manager (PBM) are not negotiated benefits and are subject to change at any time at the discretion of the PBM.



Your Dental Plan Choices at a Glance

	UNITED BASIC (any dentist)	UNITED ENHANCED (network)	CIGNA DHMO® (network only)
Annual Deductible	None	\$25 individual, \$75/family	None
Annual Maximum	None (\$500 per person for periodontics)	\$3,000 per person (excluding orthodontics)	None
Exams and X-rays	Covered at 80%	Covered at 100%	Covered at 100%
Simple Restoration			
Fillings	Covered at 80%	Covered at 80%	See examples below
Oral Surgery	Covered at 67%	Covered at 67%	See examples below
Major Restoration			
Crowns	Covered at 67%	Covered at 67%	See examples below
Dentures, Fixed Bridges	Not covered	Covered at 50%	See examples below
Orthodontia	Not covered	Plan pays \$1,500 per person per lifetime	See examples below
For example...	You pay up to:	You pay up to:	You pay up to:
Restorative (fillings)			
D2140 Amalgam - One Surface Primary/Perm	\$21.60	\$13.60	\$5.00
D2150 Amalgam - Two Surfaces Primary/Perm	\$26.80	\$17.60	\$5.00
D2392 Resin Compos - 2 Surfaces Posterior	\$35.80	\$24.60	\$50.00
Crown & Bridge			
D2530 Inlay - Metallic - 3/More Surfaces	\$293.04	\$200.64	\$350.00
D2790 Crown - Full Cast High Noble Metal	\$321.42	\$220.44	\$400.00
D6242 Pontic - Porceln Fused Noble Metal	\$877.00	\$320.00	\$380.00
D6792 Crown Full Cast Noble Metal-Denture	\$317.79	\$202.62	\$380.00
Endodontics			
D3330 Molar Root Canal	\$210.20	\$136.20	\$370.00
Oral Surgery			
D7240 Removal Impacted Tooth - Cmpl Bony	\$147.84	\$60.60	\$155.00
Prosthetics			
D5120 Complete Denture - Mandibular	Not Covered	\$409.50	\$460.00
Orthodontics			
Children under 19 - Comprehensive 24 month treatment	Not Covered	Plan Pays \$1500 maximum per person per lifetime	\$2,390
Adult - Comprehensive 24 month treatment	Not Covered	Plan Pays \$1500 maximum per person per lifetime	\$2,990

Terms to Know

Basic Plan – This plan allows you to visit any dentist or dental specialist without a referral.

Enhanced Dental PPO – This plan offers dental services both within and outside a defined network of dentists and dental specialists without a referral.

DHMO Plan – This plan provides dental services only from a defined network of dentists. You must select a primary care dentist (PCD) to coordinate all care and referrals are required for all specialist services.

Before starting extensive dental procedures for which the dentist's charges may exceed \$350, you can ask your dentist to submit a pre-treatment estimate to the Plan. You can also help to determine the amount you will be required to pay for a specific procedure by using the Plan's website.

More details about covered expenses are available by contacting the plans by phone. (See Your Benefit Resources on page 26.)

Comparing Your Plans: A Message From UnitedHealthcare Dental

UnitedHealthcare Dental offers two dental plans to State of Connecticut employees, retirees and their families. Maintaining good oral health is important to overall well being.

The Basic Plan covers most dental services and you can use any dentist or dental specialist. There is no annual deductible or calendar year maximum. Preventive care services are covered at 80%. This plan does not include coverage for sealants, orthodontia, dentures or fixed bridges.

The Enhanced Plan offers comprehensive dental care through a network of participating dentists (at a slightly lower premium). By choosing a network dentist, you maximize your value and enjoy cost savings. Unlike the Basic Plan, the Enhanced Plan includes coverage for sealants, orthodontia, dentures and fixed bridges. You may receive care outside the network, but your out-of-pocket costs will be higher.

See Your Dental Plan Choices at a Glance on page 16 and your payroll deductions on page 21 to compare your options.

Dental Value Programs Available

- A **Prenatal Dental Care** program is available for the Basic Dental Plan and Enhanced Dental plan. Taking care of teeth and gums during pregnancy is increasingly considered an important part of pre-natal care. This program provides additional preventive dental care coverage for expectant mothers in their second or third trimester of pregnancy.
- For the Enhanced Dental plan only, UnitedHealthCare Dental offers the **Consumer MaxMultiplier Rewards** program. With the Consumer MaxMultiplier, UnitedHealthcare Dental awards you for getting preventive and diagnostic dental care. Your awards are funds for your dental care that accumulate, can be carried over each year, and are there when you need them.

If you get preventive and diagnostic care during the year, but don't use up your annual benefit maximum, you will receive an award in the amount of the unused annual benefit. For example, if you use \$2,500 in benefits during the year, your award amount is \$500. (Awards are not dollars in an account, they may be used only according to Consumer MaxMultiplier program rules.) You can use your awards for both network and out-of-network claims after you reach your annual benefit maximum. However, you cannot use your awards for orthodontic services. Claims are submitted as any claim would be for dental services. Your awards will automatically fund any claims for dental services up to the amount you have in your balance during the benefit period. (The maximum balance you can accumulate is \$1,500.)

For information about Consumer MaxMultiplier, visit www.myuhcdental.com/statect and click on "Enrollment/Benefit Material."

Comparing the Basic and Enhanced Plans

As you compare the Basic Plan and the Enhanced Dental PPO, it may be helpful to look at some examples of how the plans pay certain dental treatments differently.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Example 1:	Basic Plan	Enhanced Dental PPO
Crowns	The plan pays 67% of the reasonable and customary charges in your area. Crowns are limited to 1 time per tooth per 60 consecutive months.	After you've met your annual deductible of \$25 (\$75 per family), the plan pays 67% of the discounted fee negotiated with network providers or maximum allowable charge for non-network providers. Crowns are limited to 1 time per tooth per 60 consecutive months. The plan will pay up to \$3,000 per person per calendar year for eligible expenses.
Example 2:	Basic Plan	Enhanced Dental PPO
Fixed Bridges	Not covered	After you've met your annual deductible of \$25 (\$75 per family), the plan pays 50% of the discounted fee negotiated with network providers or maximum allowable charge for non-network providers. Bridges are limited to 1 time per tooth per 60 consecutive months. If it would be equally effective, the plan may pay benefits based on the cost of a partial denture (you would be responsible for the difference). The plan will pay up to \$3,000 per person per calendar year for eligible expenses.
Example 3:	Basic Plan	Enhanced Dental PPO
Orthodontia	Not covered	The plan pays 50% of the discounted fee negotiated with network providers or maximum allowable charge for non-network providers, up to a lifetime maximum per person of \$1,500.

For further details, go to:

www.yourdentalplan.com/enrollment, **click on Enrollment Materials, and follow the link to the Basic and Enhanced Dental Plan summaries.**

If you anticipate certain dental expenses, you may want to check out the Treatment Cost Estimator at www.myuhcdental.com/statect. With a procedure code from your dentist, you can find out how the plan would pay those expenses – and, what your estimated out-of-pocket cost would be. Choose Plan Information on the left side of the screen then click on Treatment Cost Estimator. You'll need to log in with your UHC password to use this tool.

Information about benefits, covered services or finding a dentist can be found by calling customer service at **1-800-896-4834** or visiting our website **www.myuhcdental.com/statect**.

Your UnitedHealthcare Dental plan is underwritten by UnitedHealthcare Insurance Company.

Comparing Your Plans: A Message From CIGNA

CIGNA Dental Care® (DHMO¹)

You're being offered the DHMO plan² – a plan that makes it easy and affordable to take care of your dental health.

Q: What are the main features of the CIGNA DHMO plan?

A: You don't have to worry about annual dollar maximums. There are no deductibles. You'll have no claim forms to file. You will select a DHMO network general dentist³ to manage all your dental health care needs and he/she will refer you to visit any network specialist.³ You don't need a referral to visit a network orthodontist or to take children under 7 to a network pediatric dentist.³ Orthodontic coverage is available for children and adults on the DHMO plan.

Q: I am currently enrolled in the Aetna DMO Dental Plan. How do I enroll in the new CIGNA DHMO plan?

A: If you were enrolled in the DHMO plan under the previous carrier for 2007-2008, you will automatically be enrolled in the DHMO plan unless you change your election at open enrollment.

Q: If I've just joined the CIGNA DHMO plan, can I keep my current dentist?

A: If your current dentist is part of the CIGNA DHMO network, we will make every effort to assign you to that same dentist. If your current dentist is not a CIGNA DHMO dentist, you will be automatically assigned to an open CIGNA DHMO dentist office based on your home zip code. To change dentists, you can contact Customer Service.

Q: Can I receive dental care if I haven't received my ID card?

A: Yes. Your CIGNA ID card will be mailed; but it is not required to receive dental care. If you need care before your new card arrives, contact your network dental office and indicate you are a CIGNA DHMO member. If for some reason your name does not appear on the dental office roster, the office will call us to verify membership. If a problem persists, contact Customer Service.



If You Are Currently Enrolled in the Aetna DMO

If you are enrolled in the Aetna DMO for 2007-2008 and you do not return an open enrollment application to the Retirement Health Insurance Unit by June 13, 2008, you will remain enrolled in the DMO. Effective July 1, 2008, the DMO will be administered by CIGNA. Here's what this may mean to you:

- **You may have to change dentists.** Many Aetna DMO dentists also belong to the CIGNA DHMO network. However, if your dentist is not in the CIGNA DHMO network, you will be assigned to a new dentist.
- **You'll receive a new ID card.** Watch for your new ID card(s) from CIGNA.
- **If you're in the middle of certain types of treatment** on July 1, you'll complete your care under the Aetna plan.
- **The same expenses will be covered** under the CIGNA DHMO as are currently covered under the Aetna DMO. The intent is to mirror the current plan exactly.

If your current Aetna DMO dentist is not part of the CIGNA DHMO network and you do not want to change dentists, you may want to consider one of the UnitedHealthcare dental options – both allow you to use any licensed dentist.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Q: Are pre-existing conditions covered?

A: Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule; therefore, coverage starts right away.

Q: Are braces covered?

A: Your Patient Charge Schedule includes orthodontic benefits. Please refer to your plan documents in your enrollment kit for specifics. If you or your family member started treatment before you joined the CIGNA DHMO plan, please call CIGNA Customer Service to determine if a plan contribution is available.

Q: What about non-orthodontic treatment in-progress?

A: Generally, root canal treatment, crown and bridge work, and dentures in progress are not covered under the CIGNA DHMO Plan. If you are in the middle of a treatment plan on July 1, you should complete these procedures under your prior insurance plan (but you should contact that carrier before your coverage ends June 30). Refer to your plan's exclusions and limitations for more details.

¹ The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

² The CIGNA DHMO is not available in the following states: AK, HI, ME, MT, NV, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY. Out-of-network benefits are not available with the CIGNA DHMO plan.

³ CIGNA DHMO members must obtain a referral from their network general dentists in order to receive care from network specialists. Referrals are not required for network Pediatric or Orthodontic dentists.

If you still have questions after reviewing your enrollment information: Visit us on-line at www.cigna.com, or call Customer Service at **1-800-CIGNA24** (1-800-244-6224).

Once you are enrolled in a CIGNA Dental plan:

Our secure, easy-to-use web site, **myCIGNA.com**, gives you the tools to:

- **Review** your dental plan information.
- **Order** a dental ID card.
- **View** the status of dental claims.
- **Find** and change network dentist offices.
- **Get** dental health news and information from trusted sources that will help you make informed dental decisions, and much more.
- **Estimate** your out-of-pocket costs and compare the financial impact if you visit an in-network vs. an out-of-network dentist.
- **Save** through **Healthy Rewards**[®], CIGNA Dental members get access to a range of health and wellness programs and services often not covered by many traditional benefits plans. **NO REFERRALS. NO CLAIM FORMS. NO CATCH.** For information on available programs and participating providers, simply call **1-800-870-3470** or visit **myCIGNA.com**.

Some Healthy Rewards programs are not available in all states. If your CIGNA HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your medical benefits. **A discount program is NOT insurance, and the member must pay the entire discounted charge.**

Your 2008-2009 Premium Share

Monthly Dental Premiums July 1, 2008 through June 30, 2009

Subsidized Rates			
COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$22.16	\$20.39	\$23.20
2 Persons	\$44.33	\$40.78	\$51.28
3 or More Persons	\$44.33	\$40.78	\$62.94



Frequently Asked Questions

Where can I get more details about what the plans cover?

You can get more information directly from the plans at the phone numbers or websites listed on page 26.

If I live outside Connecticut, do I need to choose an Out-of-Area Plan?

Not necessarily, you may live outside Connecticut but still within a carrier's regional service area. If you live outside any of the plans' regional service areas, you may choose from one of the Out-of-Area plans.

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

A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less when you use providers in the network.

What are my options if I want access to doctors across the U.S.?

All State of Connecticut plans offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you may choose one of the Out-of-Area plans – both have national networks.

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

Contact each plan to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the plan's website (be sure to select the right network; most carriers have more than one), or you can call customer service at the numbers on page 26. It's likely your doctor is covered by at least one network.

Can I enroll later or switch plans mid-year?

Generally, the elections you make now are in effect July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 2). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

Can I enroll myself in one option and my family member in another?

No. You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental coverage. For example, you can enroll yourself and your child for medical but yourself only for dental. To enroll an eligible family member in a plan, you must enroll as well.



This Notice is directed to State of Connecticut Retirees and/or their spouses who are:

- 1. Enrolled in State Of Connecticut Retirement Health Insurance, and*
- 2. Eligible for Medicare.*

(If you do not meet these requirements please disregard this Notice)



STATE OF CONNECTICUT

NANCY WYMAN
COMPTROLLER

OFFICE OF THE STATE COMPTROLLER
55 ELM STREET
HARTFORD, CONNECTICUT 06106-1775

MARK E. OJAKIAN
DEPUTY COMPTROLLER

NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE IMPORTANT NOTICE Regarding YOUR State of Connecticut prescription drug coverage

This notice is being sent to you, as a Medicare eligible person enrolled in the State of Connecticut retiree health plan, in order to inform you of your prescription drug coverage and choices you will have for Medicare drug coverage. **Your drug coverage offered through the State of Connecticut is more comprehensive than the standard Medicare Part D prescription drug coverage. THERE IS NO NEED FOR YOU TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN.**

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Since the State of Connecticut retiree health plan provides you drug coverage that is more comprehensive than the Medicare Part D coverage, you will not need to enroll in any Medicare Rx prescription drug plans.

An individual can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiary's losing employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Medicare drug plan enrollment materials or communications may highlight potential penalties if you do not sign up when you are first eligible. **Since you already have qualified coverage and will maintain your coverage through the State of Connecticut, the late enrollment penalties will not apply to you if you decide to enroll in Medicare Rx at some later date.** However, if you drop or lose coverage with the State of Connecticut retiree health plan and do not enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without any prescription drug coverage that is at least as good as the Medicare prescription drug coverage, your monthly premium may go up by at least 1% of the base premium per month, for every month that you did not have coverage. For example, if you drop the State's coverage and do not sign up for Medicare prescription drug coverage for 19 months, your Medicare D premiums will be 119% of the standard Medicare D premium.

This notice is proof to Medicare that you have maintained coverage and that coverage is at least as good as the benefits offered by Medicare. You will not incur the penalty if you do not have a lapse in equivalent coverage.

If you decide to enroll in a Medicare prescription drug plan, be aware: You may not be able to get the State of Connecticut prescription drug coverage back.

It is very important for you to know the following information:

- The enrollment period for Medicare prescription drug plans is when you become eligible for Medicare, and each year from November 15 through December 31st each year – **You do not need to take any action.**
- The Medicare prescription drug coverage (Medicare D) is available to everyone eligible for Medicare. – **You do not need to take any action.**
- The State of Connecticut retiree health plan has determined that your prescription drug benefits are better than the standard Medicare prescription drug coverage. – **You need to keep a copy of this notice for you records.**

Detailed information regarding Medicare plans are available in the *Medicare and You Handbook*. If you are Medicare eligible you will receive a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You may also obtain more information about Medicare prescription drug plans from the following:

- On the web at www.medicare.gov,
- Call your State Health Insurance Assistance Program (In Connecticut, CHOICES at 1-800-994-9422
- Call 1-800-Medicare (1-800-633-4227)
- People with limited income and resources can contact the Social Security Administration at www.socialsecurity.gov, or call 1-800-772-1213 to discuss potential financial assistance.

Should you have any questions regarding this notice, please contact the Retirement Health Insurance Unit at 860-702-3533.

KEEP THIS NOTICE. If you enroll in one of the new prescription drug plans approved by Medicare, you may need to give a copy of this notice when you join in order to show that you are not required to pay premium penalty. **This notice is proof to Medicare that the State of Connecticut's prescription drug plan is at least as good as the benefits offered by Medicare.**

Revised 04/04/07

Your Benefit Resources

For details about specific plan benefits and network providers, contact the individual plan. If you have questions about eligibility, enrolling in the plans or deductions, contact the Retirement Health Insurance Unit at 860-702-3533.

Anthem Blue Cross and Blue Shield <ul style="list-style-type: none"> • Anthem State Preferred POS • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus • Anthem State Preferred Out of Area 	Anthem.com/statect	1-800-922-2232
Health Net <ul style="list-style-type: none"> • Health Net Charter (POS) • Health Net Charter HMO • Health Net Passport HMO 	Healthnet.com/stateofct	1-800-255-5019
UnitedHealthcare (Medical) <ul style="list-style-type: none"> • Oxford Freedom Select • Oxford HMO Select (POE) • Oxford HMO • Oxford USA Out of Area 	Oxfordhealth.com/stateofct	1-800-385-9055 Call 1-800-760-4566 for questions before you enroll
Caremark (Prescription drug benefits, any medical plan)	Caremark.com/members/stateofct	1-800-318-2572
UnitedHealthcare (Dental) <ul style="list-style-type: none"> • Basic Plan • Enhanced PPO 	Myuhcdental.com/statect	1-800-896-4834
CIGNA <ul style="list-style-type: none"> • DHMO Plan 	Cigna.com	1-800-244-6224



**RETIREMENT HEALTH INSURANCE
OPEN ENROLLMENT APPLICATION**
CO-1048-R REV. 5/2008

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT & BENEFIT SERVICES DIVISION
RETIREMENT HEALTH INSURANCE UNIT
55 ELM STREET
HARTFORD, CT 06106-1775
www.osc.state.ct.us

TYPE OR PRINT

RETIREE NAME (Person Receiving Benefit)		EMPLOYEE NUMBER (from active employment)	
MAILING ADDRESS		TELEPHONE NUMBER	CURRENT INSURANCE CARRIER

I. MEDICAL INSURANCE

CHECK ONE BLOCK TO INDICATE THE TYPE OF COVERAGE YOU ARE ELECTING FOR YOURSELF AND YOUR COVERED DEPENDENTS

ANTHEM	HEALTH NET	OXFORD
<input type="checkbox"/> 1. State BlueCare POS <input type="checkbox"/> 2. State BlueCare POE <input type="checkbox"/> 3. State BlueCare POE Plus (POE-G) <input type="checkbox"/> 4. State Preferred POS <input type="checkbox"/> 5. Out of Area Plan – Only if Retiree’s Permanent Residence is Outside of Connecticut	<input type="checkbox"/> 6. Charter POS <input type="checkbox"/> 7. Charter HMO (POE) <input type="checkbox"/> 8. Passport HMO (POE-G)	<input type="checkbox"/> 9. Oxford Freedom Select POS <input type="checkbox"/> 10. Oxford HMO Select POE <input type="checkbox"/> 11. Oxford HMO (POE-G) <input type="checkbox"/> 12. Oxford USA POS Out of Area Plan – Only if Retiree’s Permanent Residence is Outside of Connecticut

LIST INDIVIDUALS TO BE COVERED UNDER MEDICAL INSURANCE. 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.

RETIREE NAME	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
SPOUSE’S NAME	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
DEPENDENT CHILD	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER		FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT CHILD	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER		FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO

FOR UNMARRIED, FULL-TIME STUDENT(S), AGE 19-23, PLEASE INDICATE NAME OF ACCREDITED INSTITUTION(S):

COORDINATION OF BENEFITS – APPLICATION IS INVALID UNLESS THIS SECTION IS COMPLETED

WHEN YOU ARE COVERED BY THE HEALTH PLAN SELECTED, WILL YOU OR YOUR DEPENDENT(S) HAVE ANY OTHER COVERAGE? YES NO

IF YES, WHICH FAMILY MEMBER(S) WILL BE COVERED BY THAT INSURANCE (CHECK OFF AS MANY THAT APPLY)

SELF SPOUSE CHILDREN (LIST NAMES)

NAME OF PLAN	ADDRESS:
POLICY NUMBER	NAME OF PERSON(S) POLICY ISSUED TO
EFFECTIVE DATE	COMPANY THROUGH WHICH COVERAGE OBTAINED

IS ANY MEMBER LISTED ABOVE ELIGIBLE FOR MEDICARE? YES NO

IF YES GIVE MEDICARE PART A (HOSPITAL INSURANCE) AND MEDICARE PART B (MEDICAL INSURANCE) EFFECTIVE DATE(S)

RETIREE		SPOUSE		DEPENDENT CHILD		DEPENDENT CHILD	
PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)

II. DENTAL INSURANCE

CHECK ONE BLOCK TO INDICATE THE TYPE OF COVERAGE YOU ARE ELECTING FOR YOURSELF AND YOUR COVERED DEPENDENTS.
NOTE: COVERAGE FOR DEPENDENT CHILDREN ENDS AT AGE 19

UNITED BASIC DENTAL UNITED ENHANCED DENTAL PPO CIGNA DENTAL DHMO

LIST INDIVIDUALS TO BE COVERED UNDER DENTAL INSURANCE:

RETIREE NAME	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SPOUSE’S NAME	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
DEPENDENT CHILD	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
DEPENDENT CHILD	SEX <input type="checkbox"/> F <input type="checkbox"/> M	DATE OF BIRTH	SOCIAL SECURITY NUMBER

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 will be available subject to the 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, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s). I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE
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Retirement & Benefit Services Division
Office of the State Comptroller
55 Elm Street
Hartford, CT 06106-1775

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*Important information for
Aetna Dental HMO members on page 19!*

HEALTHCARE OPTIONS PLANNER 2008 - 2009

FOR STATE OF CONNECTICUT
RETIREES



Retirement Date Prior to July 1997

Explore Your Options —
Expanded Provider Networks This Year