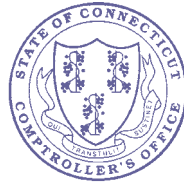


For State of Connecticut

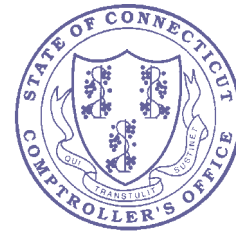


# Retirees



**HEALTHCARE OPTIONS PLANNER**

# 2010-2011



## 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 affects your health and what you pay out of pocket for your healthcare. 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.

You may be able to change your plan, keep seeing the same doctors, and reduce your payroll deduction for health insurance.

Please note that Health Net will no longer be an option for you since they are closing their business in the Northeast. Health Net participants will have the option of choosing either UnitedHealthcare/Oxford or Anthem.

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 2010

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# What You Need to Do

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.)

## How to Use This Planner

This planner is for all State of Connecticut retirees. Most of the information applies to all retirees. However, there are some differences depending on your retirement date. The “Your Medical Plans at a Glance,” “Your Prescription Drug Coverage at a Glance,” and “Your 2010-2011 Premium Share” pages are customized and color-coded by group.

If your **retirement date is before July 1997**, watch for the information printed in **red** on the following pages that applies specifically to you:

Your Medical Plans at a Glance – page 4

Your Prescription Drug Coverage at a Glance – page 18

Your 2010-2011 Premium Share – page 26

If your **retirement date is between July 1, 1997 and May 1, 2009 (or you retired under the 2009 Retirement Incentive Program)**, watch for the information printed in **blue** on the following pages that applies specifically to you:

Your Medical Plans at a Glance – page 5

Your Prescription Drug Coverage at a Glance – page 19

Your 2010-2011 Premium Share – page 27

If your **retirement date is June 1, 2009 or later**, watch for the information printed in **green** on the following pages that applies specifically to you:

Your Medical Plans at a Glance – page 6

Your Prescription Drug Coverage at a Glance – page 20

Your 2010-2011 Premium Share – page 28

All other pages printed in **purple**.

**For 2010 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.**

## Current Retirees

### Open Enrollment Through June 4, 2010

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.

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. If you have a question concerning your enrollment, contact the Retirement Health Insurance Unit at the address below or call (860) 702-3533.

Complete and return the form in the back of this booklet if you’d like to make a change for 2010-2011. The form must be postmarked by June 4, 2010. Any changes you make are effective July 1, 2010 through June 30, 2011 unless you have a qualifying status change. Unless you’re enrolled in a Health Net plan, 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 26, 27 or 28 (as applicable). If you’re currently enrolled in a Health Net plan, see page 7.

### Return completed enrollment forms to:

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

## New Retirees

To enroll for the first time, follow these steps:

1. Review this booklet and choose the medical and dental options that best meet your needs.
2. Complete the enrollment form (Form 744 – Choice of Health Insurance After Retirement) included in your retirement packet; this form is different from the one included in this booklet for open enrollment.
3. Return the form with your retirement packet.

If you enroll as a new retiree, your coverage begins the first day of the second month of your retirement. For example, if your retirement date is October 1, your coverage begins November 1. If you waive coverage when you’re initially eligible, you may enroll within 31 days of losing other coverage, or during any open enrollment period.



## 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 – which 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.
- **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 or your 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.
- **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).

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**This planner provides a brief summary of covered expenses. See Your Benefit Resources on page 33 to receive more detailed information.**

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# Your Medical Plans at a Glance

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

# Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS		BOTH CARRIERS
	POE, POE-G AND OUT-OF-AREA IN NETWORK	POS IN NETWORK	POS OUT-OF-NETWORK
<b>Annual Deductible</b>			
Each Individual		None	\$300
Family (3 or more)		None	\$900
<b>Annual Out-of-Pocket Maximums</b>			
Each Individual		None	\$2,000 (plus deductible)
Family		None	\$4,000 (plus deductible)
<b>Coinsurance</b>		None	You pay 20% of allowable charge plus**
<b>Lifetime Maximum</b>		None	None
<b>Outpatient Physician Visits</b>	\$10 copay*	\$15 copay*	80%
<b>Preventive Care</b>			
Children	No copayment for well-child visits and immunizations		80%
Adults	\$5 copay***		
<b>Family Planning</b>			
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)
<b>Inpatient Physician</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Inpatient Hospital</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Outpatient Surgical Facility</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Ambulance</b>	100% (if emergency)		100% (if emergency)
<b>Pre-admission Certification/ Concurrent Review</b>	Through participating provider		Penalty of 20% up to \$500 for no certification
<b>Mental Health</b>	Pre-certification required		Pre-certification required
Inpatient	100%		80%
Outpatient	\$10 copay*	\$15 copay*	80%
<b>Substance Abuse</b>	Pre-certification required		Pre-certification required
Detoxification	100%		80%
Inpatient	100%		80%
Outpatient	\$10 copay*	\$15 copay*	80%
<b>Skilled Nursing Facility</b>	100% (pre-certification required)		80%, up to 60 days/year (pre-certification required)
<b>Home Health Care</b>	100% (pre-certification required)		80%, up to 200 visits/year (pre-certification required)
<b>Hospice</b>	100% (pre-certification required)		80%, up to 60 days (pre-certification required)
<b>Short Term Rehabilitation and Physical Therapy</b>	100%		80%, up to 60 inpatient days, 30 outpatient days per condition per year
<b>Diagnostic X-Ray and Lab</b>	100%		80%
<b>Pre-Admission Testing</b>	100%		80%
<b>Urgent or Emergency Care</b>	100%		100%
<b>Durable Medical Equipment</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Prosthetics</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Routine Eye Exam</b>	\$15 copay, 1 exam per year		50%, 1 exam every 2 years
<b>Audiological Screening</b>	\$15 copay, 1 exam per year		80%, 1 exam per year

\* \$5 copay for retirees who retired before July 1, 1999.

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

\*\*\* Note: For adult physical examinations and routine gynecological examinations and Pap smears pursuant to carrier plan schedules.

# Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS		BOTH CARRIERS
	POE, POE-G AND OUT-OF-AREA IN NETWORK	POS IN NETWORK	POS OUT-OF-NETWORK
<b>Annual Deductible</b>			
Each Individual		None	\$300
Family (3 or more)		None	\$900
<b>Annual Out-of-Pocket Maximums</b>			
Each Individual		None	\$2,000 (plus deductible)
Family		None	\$4,000 (plus deductible)
<b>Coinsurance</b>		None	You pay 20% of allowable charge plus**
<b>Lifetime Maximum</b>		None	None
<b>Outpatient Physician Visits</b>	\$10 copay	\$15 copay	80%
<b>Preventive Care</b>			
Children	No copayment for well-child visits and immunizations		80%
Adults	\$5 copay*		
<b>Family Planning</b>			
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)
<b>Inpatient Physician</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Inpatient Hospital</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Outpatient Surgical Facility</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Ambulance</b>	100% (if emergency)		100% (if emergency)
<b>Pre-admission Certification/ Concurrent Review</b>	Through participating provider		Penalty of 20% up to \$500 for no certification
<b>Mental Health</b>	Pre-certification required		Pre-certification required
Inpatient	100%		80%
Outpatient	\$10 copay	\$15 copay	80%
<b>Substance Abuse</b>	Pre-certification required		Pre-certification required
Detoxification	100%		80%
Inpatient	100%		80%
Outpatient	\$10 copay	\$15 copay	80%
<b>Skilled Nursing Facility</b>	100% (pre-certification required)		80%, up to 60 days/year (pre-certification required)
<b>Home Health Care</b>	100% (pre-certification required)		80%, up to 200 visits/year (pre-certification required)
<b>Hospice</b>	100% (pre-certification required)		80%, up to 60 days (pre-certification required)
<b>Short Term Rehabilitation and Physical Therapy</b>	100%		80%, up to 60 inpatient days, 30 outpatient days per condition per year
<b>Diagnostic X-Ray and Lab</b>	100%		80%
<b>Pre-Admission Testing</b>	100%		80%
<b>Urgent or Emergency Care</b>	100%		100%
<b>Durable Medical Equipment</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Prosthetics</b>	100% (pre-certification required)		80% (pre-certification required)
<b>Routine Eye Exam</b>	\$15 copay, 1 exam per year		50%, 1 exam every 2 years
<b>Audiological Screening</b>	\$15 copay, 1 exam per year		80%, 1 exam per year

\* Note: For adult physical examinations and routine gynecological examinations and Pap smears pursuant to carrier plan schedules.

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

# What's New for 2010-2011

There are no benefit changes effective July 1, 2010. However, new premium share rates are listed on pages 26 - 28 and the Health Net plan options are no longer available.

## Health Net Members Need to Select New Plan

UnitedHealthcare has acquired Health Net of the Northeast's product licenses. That means if you are currently enrolled in a Health Net plan, you will have a new plan effective July 1. The good news is that no matter which type of plan you prefer - Point of Enrollment-Gatekeeper (POE-G), Point of Enrollment (POE), or Point of Service (POS) - you have your choice of a UnitedHealthcare Oxford or Anthem plan.

Remember, each of the medical plan options offered by the State of Connecticut is designed to cover the same services and supplies. The main differences among the plan options are how you access services (whether you need to select a PCP, use network providers only or have the option to go in or out of network) and the provider networks.

Most Health Net providers are also in the UnitedHealthcare and Anthem networks. Check with your provider (or contact the insurance carrier) to find out if he or she participates in one or more of the networks available through the other plan options. You may be able to keep your provider while choosing from among several plans.

### If You Do Nothing

If you don't complete and return an enrollment form by the deadline, you and your currently enrolled family members will be transferred into the UnitedHealthcare Oxford medical plan option closest to your Health Net plan.

<b>If You're Currently Enrolled in...</b>	<b>You'll Be Placed in...</b>
Health Net Passport HMO (POE-G)	UnitedHealthcare Oxford HMO (POE-G)
Health Net Charter HMO (POE)	UnitedHealthcare Oxford HMO Select (POE)
Health Net Charter (POS)	UnitedHealthcare Oxford Freedom Select (POS)

### What's Next

You should receive your new Oxford or Anthem medical plan card on or about July 1 when your new plan takes effect. Call the insurance carrier for your new plan if you don't receive your new ID card in early July. Through June 30, keep using your Health Net plan as usual.

If you have questions about the new plan options you're considering, contact UnitedHealthcare Oxford or Anthem as applicable. Plan contact information is listed on page 33.

The first time you visit your doctor after July 1, be sure to let their office know that you have a new plan and show them your new card so the billing can be handled smoothly.

### For 2010 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.

## Your Prescription Drug Benefit Is Not Changing

Although your medical plan option is changing July 1, there is no change to your prescription drug benefits. The prescription drug benefit manager is still Caremark and there are no changes to copay amounts. Keep using your current prescription drug card – you will not receive a new one. (You may still be using a PharmaCare card and that’s just fine; it still works.)

## You May Be Asking

**What if I don’t want the plan that I’m being placed into?** We hope that each current Health Net plan participant will review this planner and actively select a new plan. We will only “place” you in a new plan if you do not respond by the deadline.

You have until June 4 to choose a new plan. You may enroll in any of the available Oxford or Anthem plans offered by the State of Connecticut. See page 11 for a chart that lists each of the plan options and compares major features. Also, you can read more about Oxford and Anthem on pages 12 – 15.

**Is my doctor in the network?** Check with your doctor to find out if he or she participates in the network associated with the plan option you’re considering. Anthem and UnitedHealthcare Oxford each have more than one network so be sure to specify the plan name to be sure you’re checking against the correct network.

## Dependents up to Age 26

Eligible dependents can now be covered under the medical and prescription drug plans through the end of the month in which they turn age 26 on a pre-tax basis. Dental coverage for dependents ends at age 19 (unless disabled).

# 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. Yet, your premium share varies quite a bit from plan to plan. 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 pages 4, 5 or 6, as applicable.)
- 2. Cost** – what you pay when you receive medical care and what is deducted from your pension check. What you pay at the time you receive services is similar across the plans (see the chart on pages 4, 5 or 6, as applicable). However, your premium share varies quite a bit (see pages 26, 27 or 28, as applicable).
- 3. Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 9 and 10.)
- 4. Plan features** – how you access care and what kinds of “extras” the insurance carrier 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 insurance carrier over the other (see pages 12 – 15).

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

# 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. Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same healthcare services?

Many doctors belong to multiple provider networks. 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. You may be able to save money every month without changing doctors.

## 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 insurance carrier 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. If you retired after July 1997, your in-network copays are also higher under a POS plan than under a POE or POE-G plan.

## 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 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. 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 precertification 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 precertification requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require pre-certification (see page 4, 5 or 6, as applicable), 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 or Work Affects Your Choices

You must live or work 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 UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the Oxford regional provider network. If you live and work outside that area, you should choose one of the Out-of-Area plans. Both Out-of-Area 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 33 for phone numbers and websites.)
- **Discounts** – Both insurance carriers offer discounts to members for certain health-related expenses such as gym memberships and eyeglasses.

## About Value-Added Programs

Another area where the insurance carriers 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:

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

Because these value-added programs are not plan benefits, they are subject to change at any time by the insurance carrier. However, you may want to see what each company 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	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford USA
National network	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available					X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X					
No referrals required for care from in-network providers			X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X							

\* Closed to enrollment.

# Comparing Plans: A Message From Anthem

## Anthem Blue Cross and Blue Shield Offerings

	State BlueCare POE Plus In Network	State BlueCare POE In Network	State BlueCare POS In/Out-of-Network	Anthem Out of Area Plan
Office Visit Copay	\$10*	\$10*	\$15*	\$15*
Specialist Copay	\$10*	\$10*	\$15*	\$15*
Specialist Referral	Yes	No	No	No
Local & National Provider Networks	Yes	Yes	Yes	Yes
Hospital Network	Local and national	Local and national	Local and national	Local and national
National Access	Yes	Yes	Yes	Yes
International Access	Yes	Yes	Yes	Yes

\* Retiree copays may vary



*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.*

If you don't have a Primary Care Physician (PCP), you can select one at [anthem.com/stategct](http://anthem.com/stategct)

State BlueCare POS, State BlueCare POE and State BlueCare POE Plus feature national and international access. State of Connecticut employees and retirees who reside in Connecticut, Massachusetts or Rhode Island can enroll in any State BlueCare plan and select a Primary Care Physician.

To find a provider, call 1-800-810-BLUE (2583) or visit our website at [anthem.com/stategct](http://anthem.com/stategct).

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.

Your trusted partner in health with local, dedicated service

For more than 50 years, we've been proud to serve State of Connecticut employees, retirees and their families with the kind of local, dedicated service you deserve. We're here to help you get the most out of your health benefits and wellness programs so that you can stay on top of your health.

- Local, State-dedicated Member Services Unit full of knowledgeable, caring people
- Local, onsite dedicated retiree specialist
- State-dedicated website to find a doctor, check claims, order ID cards and more

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# Your trusted partner in health, today and tomorrow.

With wellness programs designed to support and guide you through your health care decisions.

## 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.

- **Tools & Resources** – Get info on wellness, health topics and specific conditions 24/7 online or through our Audio Tape Library and NurseLine. 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 Condition Care programs and the Neonatal Intensive Care Unit program.
- **ConditionCare** – If you or someone you love suffers from a chronic medical condition, help is just a phone call away. Our ConditionCare nurses help people of all ages manage the symptoms of asthma, diabetes, heart failure, chronic kidney disease and chronic obstructive pulmonary disease. With ConditionCare you'll get the information you need to feel your very best — day after day. Our ConditionCare nurses gather information from you and your doctor to help you follow a personalized care plan.

Sign up for ConditionCare at no additional cost or obligation by calling the toll-free number listed on your ID card. Information and encouragement are a phone call away.

## SpecialOffers@Anthem<sup>SM</sup>

As a State employee or retiree, you can access discounts on all kinds of healthy living products and services by visiting [anthem.com/statect](http://anthem.com/statect). These are just a few of the discounts available:

- Weight loss programs – Weight Watchers®, Jenny Craig®, Lindora Online™, LivingLean
- Fitness club memberships, fitness equipment, coaching

- Hearing aids
- Allergy products
- Acupuncture
- Massage therapy
- Barnes and Noble
- Baby products and supplies
- Senior Care products and services

## 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 up to 30% on eyeglasses, 25% on nonprescription sunglasses and enjoy discounted prices on exams. Choose from private practitioners or leading optical retailers including LensCrafters®, Target® Optical, Sears Optical, JC Penney Optical and most 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.

### LCA Vision

Save 15% on LASIK with all in-network providers and prices as low as \$695 per eye with “select” providers. The Premier Lasik Network is one of the largest surgeon networks in the U.S. with more than 550 provider locations offering the latest technologies in the industry.

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

Need a medical procedure? Use Anthem Care Comparison to see side-by-side cost comparisons of medical procedures at area hospitals and other medical facilities.

# 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

Our plans provide the same benefits and cover the same services as all of the plans offered to State of Connecticut employees and retirees at a lower premium cost to you and your family. It's no wonder UnitedHealthcare, featuring State of Connecticut Oxford plans, is the fastest growing carrier choice for State of Connecticut employees.

In addition, every Oxford plan provides access to our seamless national network of physicians and health care professionals and our regional network in Connecticut, New York and New Jersey. We provide access to many of the top hospitals nationwide - **including all 33 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 premium cost shares low. 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 premium rates.
- Oxford plans are the lowest premium cost options of all plans offered to State of Connecticut employees and cover all the same services.

### 2) Visit the Web site to search for a doctor

- **Log in** to [www.oxhp.com/stateofct](http://www.oxhp.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, click "Search outside the Oxford service area."
- 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 plan<sup>1</sup> 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<sup>®</sup>** 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.oxhp.com/stateofct](http://www.oxhp.com/stateofct).<sup>1</sup>

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.oxhp.com/stateofct](http://www.oxhp.com/stateofct)**

**Dental Coverage  
Dedicated Service Center  
1-800-896-4834  
[www.myuhcdental.com/statect](http://www.myuhcdental.com/statect)**



<sup>1</sup> Offers are valid through December 31, 2010. 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.

# Frequently Asked Questions

## ***Where can I get more details about what the State Health Insurance Plan covers?***

All medical plans offered by the State of Connecticut cover the same services and supplies. For more detailed benefit descriptions and information about how to access the plan's services, contact the insurance carriers at the phone numbers or websites listed on page 33.

## ***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. Contact Anthem and/or UnitedHealthcare Oxford to find out which plans offer providers in your area.

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

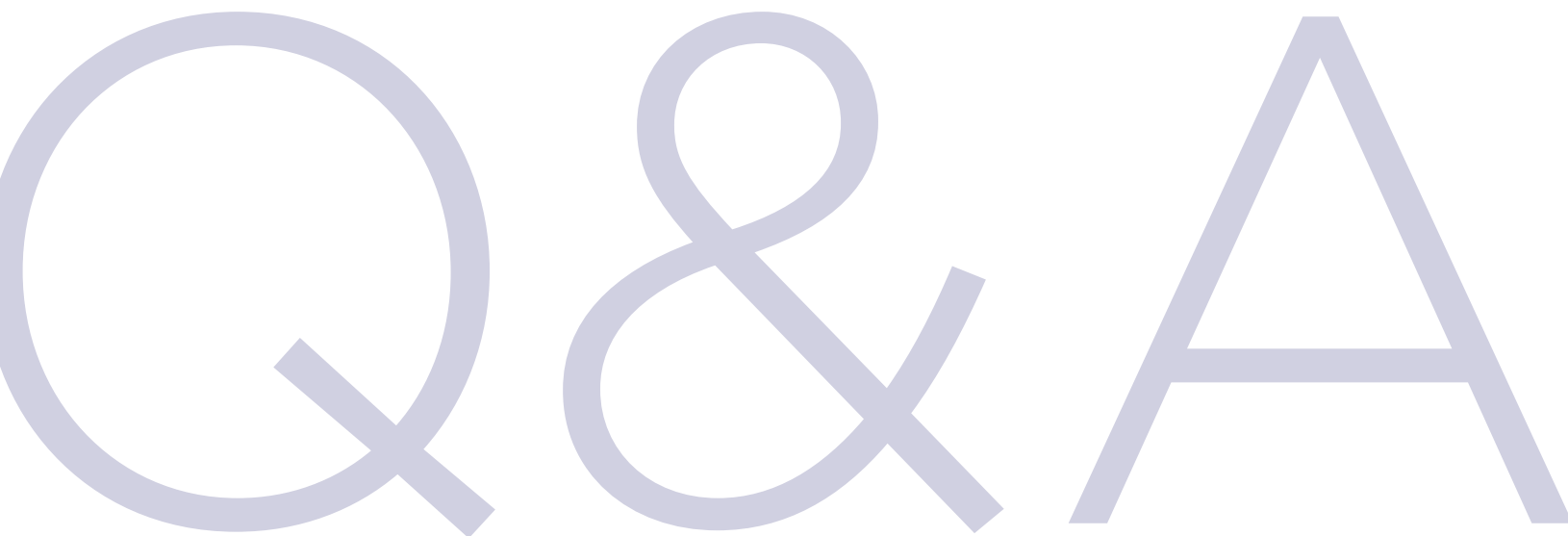
A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less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

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

Both State of Connecticut insurance carriers 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 insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 33. It's likely your doctor is covered by more than 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 3). 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.



# Your Prescription Drug Coverage at a Glance

## Save Money with a 3-month Supply

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.

Your prescription drug coverage is through 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 or a brand-name drug and where you purchase your prescriptions:

At a **Caremark network pharmacy**, for each 34-day supply (3-month supply for maintenance drugs):

- Generic drugs – \$3
- Brand-name drugs (if no generic available or medically necessary) – \$6
- Brand-name drugs (if generic available) – \$3 PLUS the difference in cost between the brand and generic drug

Through the **Caremark mail-order pharmacy**, for each 3-month supply (maintenance drugs):

- Generic drugs – \$3
- Brand-name drugs (if no generic available or medically necessary) – \$6
- Brand-name drugs (if generic available) – \$3 PLUS the difference in cost between the brand and generic drug

At an **out-of-network pharmacy**:

- You pay 20% of the cost of the prescription.

## If You Choose a Brand-Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted above, if you choose a brand-name drug over a generic alternative and it is not approved as medically necessary, you will pay the generic drug copay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572.

## CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 800-237-2767 for information.

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# Your Prescription Drug Coverage at a Glance

## Save Money with a 3-month Supply

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?

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Your prescription drug coverage is through Caremark. Prescription benefits are the same no matter which medical plan you choose.

The plan has a 3-tier copay structure which means the amount you pay depends on whether your prescription is for a generic drug, a brand-name drug listed on Caremark's preferred drug list (the formulary), or a non-preferred brand-name drug. Your copay is the same whether you fill a 34-day supply at a retail pharmacy or a 90-day supply through the mail-order program.

Prescription Tier	Amount you pay
Tier 1: Generic drug	\$5
Tier 2: Preferred brand-name drug	\$10
Tier 3: Non-preferred brand-name drug	\$25 (\$10 if your physician certifies the non-preferred brand-name drug is medically necessary)

To check which copay amount applies to your prescriptions, visit [www.Caremark.com](http://www.Caremark.com) for the most up-to-date information. Once you register, click on "Look up Co-pay and Formulary Status." Simply type the name of the drug you want to look up and you will see the cost and copay amounts for that drug as well as alternatives.

## Preferred and Non-Preferred Brand-Name Drugs

Which tier a drug is placed in is determined by Caremark. Caremark's Pharmacy and Therapeutics Committee reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at <http://www.osc.state.ct.us/empret/indxhlth.htm>) and fax it to Caremark. If approved, you will pay the preferred brand copay amount.

## If You Choose a Brand-Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted above, if you choose a brand-name drug over a generic alternative and it is not approved as medically necessary, you will pay the generic drug copay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572.

## CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 800-237-2767 for information.



# Your Dental Plan Choices at a Glance

	<b>UNITED BASIC</b> (any dentist)	<b>UNITED ENHANCED</b> (network)	<b>CIGNA DHMO®</b> (network only)
<b>Annual Deductible</b>	None	\$25 individual, \$75/family	None
<b>Annual Maximum</b>	None (\$500 per person for periodontics)	\$3,000 per person (excluding orthodontics)	None
<b>Exams and X-rays</b>	Covered at 80%	Covered at 100%	Covered at 100%
<b>Simple Restoration</b>			
Fillings	Covered at 80%	Covered at 80%	Covered*
Oral Surgery	Covered at 67%	Covered at 67%	Covered*
<b>Major Restoration</b>			
Crowns	Covered at 67%	Covered at 67%	Covered*
Dentures, Fixed Bridges	Not covered	Covered at 50%	Covered*
<b>Orthodontia</b>	Not covered	Plan pays \$1,500 per person per lifetime	Covered*

\* Contact CIGNA at 1-800-244-6224 for patient copay amounts.

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 33.)

## 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.

Dental coverage ends for dependent children at age 19 (unless disabled).

# 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 (except for periodontics, which has a \$500 annual 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 21 and your premium share on pages 26, 27 or 28 (as applicable) 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 prenatal 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 have preventive and diagnostic care during the year but don't use up your annual benefit maximum, you will receive a portion of the unused annual benefit. For example, the Enhanced calendar maximum is \$3,000 and you use only \$1,250 in benefits during the calendar year, your award amount is \$700. (Awards are not dollars in an account; they may be used only according to Consumer MaxMultiplier program rules.)

Additionally, you are awarded \$100 if you receive all your care from a participating network dentist. Awards are calculated for the following year. You can use your awards for both network and out-of-network claims. 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 once you exceed your benefit period maximum and up to the amount you have in your award balance. (The maximum balance you can accumulate for this example would be \$5,250.)

For information about Consumer MaxMultiplier, visit [www.myuhcdental.com/staect](http://www.myuhcdental.com/staect) 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.

Example 1:	Basic Plan	Enhanced Dental PPO
<b>Crowns</b>	The plan pays 67% of the billed 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
<b>Fixed Bridges</b>	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
<b>Orthodontia</b>	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.

*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 further details, go to:

**[www.yourdentalplan.com/enrollment](http://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](http://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 Calculator. 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 Web site **[www.myuhcdental.com/statect](http://www.myuhcdental.com/statect)**.

## Enhanced Dental PPO: Using Network Dentists Pays

If you join the Enhanced Dental PPO it's important to know that using network dentists can result in real savings for you. For example, if you visit a network dentist for a cleaning the network fee might be \$57 – the plan would pay \$57 and your cost would be zero. If you saw an out-of-network dentist the charge could be the national average of \$78 – the plan would pay \$57 (100% of the discounted fee) and you pay the rest – your cost would be \$21.

# Comparing Your Plans: A Message From CIGNA

## Why enroll in the CIGNA Dental Care® (DHMO)?

The CIGNA DHMO makes it easy and affordable to take care of your dental health!

[www.cigna.com](http://www.cigna.com) • 1.800.CIGNA24 (1-800-244-6224).



*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.*

## The Importance of Good Oral Care

Did you know that most preventive dental care has \$0 or low copay thus encouraging preventive care, which often catches minor problems before they become major and expensive to treat. And healthier gums may:

- Help reduce pre-term birth
- Lead to a healthier heart
- Help control blood sugar

## New for 2010:

### Enhanced preventive coverage available for eligible employees who enroll

Research indicates that poor dental health is related to an increased risk of developing complications for major illnesses such as diabetes, heart disease and stroke; and it is a factor in pre-term births.<sup>2</sup> Therefore, eligible State of Connecticut employees who enroll in the CIGNA DHMO plan will have access to enhanced coverage through the **CIGNA Dental Oral Health Integration Program.**<sup>®</sup>

With this program, eligible customers with certain conditions may receive 100% reimbursement of their copay for select covered services.\* Sample procedures include: Periodontal root scaling and planing—sometimes referred to as “deep cleaning” (procedure codes D4341, D4342) and Periodontal maintenance (procedure code D4910). Review your enrollment kit materials for more information.

## Key Highlights of the CIGNA DHMO

This plan offers coverage for a wide range of services at a cost savings. Coverage includes:

- Preventive care (cleanings, x-rays, and more)
- Basic care (fillings, basic restorative work)
- Major services (bridges, crowns, root canals and more)

## Key Features of the CIGNA DHMO

- NO waiting periods
- NO deductibles
- NO dollar maximums
- NO claim forms
- No referrals required for children under seven to visit a network pediatric dentist
- No referrals required to receive care from a network Orthodontist
- No age limit on sealants, which help prevent tooth decay

Review your enrollment kit materials carefully before you enroll.

**If you have more questions,** visit us on-line at [www.cigna.com](http://www.cigna.com) or call us for LIVE assistance 24/7 at **1-800-CIGNA24** (1-800-244-6224).

Once you are enrolled in the CIGNA DHMO:

**Register for our secure, easy-to-use web site, myCIGNA.com, and get the tools to:**

- **Review** your dental plan information.
- **Order** a dental ID card.<sup>3</sup>
- **Find** and change network dentist offices.<sup>4</sup>
- **Get** dental health news and information from trusted sources that can help you make informed dental decisions.

### **Enjoy health and wellness discounts!**

Save money when you purchase health and wellness products and services through the **CIGNA Healthy Rewards® program.\*\*** Offers include discounts on weight and nutrition management, tobacco cessation, vision and hearing care, anti-cavity products and more. Call 1-800-870-3470 or visit **myCIGNA.com** for details.

<sup>1</sup>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. 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.

<sup>2</sup>www.ada.org, November 2004.

<sup>3</sup>You will receive an ID card when you enroll for the first time as a new CIGNA DHMO customer, but it is not required to receive care.

<sup>4</sup>Information listed in this directory is not guaranteed and may be subject to change without notice. Revisions to this directory may not be made immediately. Since CIGNA Dental Care® (DHMO) customers require referrals to receive care from all network specialists except for orthodontists and pediatric dentists (for covered children under age 7), search results include only General Dentists, orthodontists, and pediatric dentists.

\* These enhanced benefits are subject to your plan's limitation except for periodontal maintenance (D4910) where the frequency limitation has been increased to four times per year.

\*\* 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 coverage. Healthy Rewards programs are separate from your medical coverage. **A discount program is NOT insurance, and you must pay the entire discounted charge.**



# Your 2010-2011 Premium Share

There is no premium share for medical plans.

## Monthly Dental Premiums July 1, 2010 through June 30, 2011

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$25.12	\$23.10	\$26.93
2 Persons	\$50.24	\$46.21	\$59.24
3 or More Persons	\$50.24	\$46.21	\$72.71



# Your 2010-2011 Premium Share

## Monthly Medical Premiums July 1, 2010 through June 30, 2011

Medical plan options with no retiree premium share:

Point of Enrollment - Gatekeeper Plans	Point of Enrollment Plans	Out-of-Area Plans
Anthem State BlueCare POE Plus UnitedHealthcare Oxford HMO	Anthem State BlueCare POE UnitedHealthcare Oxford HMO Select	UnitedHealthcare Oxford USA Out of Area plan Anthem Out-of-Area plan

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	ANTHEM STATE PREFERRED POS Closed to New Enrollment		UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS
	Retirement Date 7/1/99 and Later	Non-ERIP Retirement Date 7/97 - 6/99	Retirement Date 7/1/99 and Later	Retirement Date 7/1/99 and Later
1 Person on Medicare	\$0.00	\$0.00	\$0.00	\$0.00
1 Person not on Medicare	\$12.85	\$41.73	\$44.38	\$13.23
1 Person not on Medicare and 1 on Medicare	\$12.85	\$39.08	\$43.87	\$13.23
1 not on Medicare and 2 on Medicare	\$12.85	\$7.16	\$32.05	\$13.23
2 on Medicare	\$0.00	\$0.00	\$0.00	\$0.00
2 not on Medicare	\$28.27	\$92.18	\$98.00	\$29.10
2 not on Medicare and 1 on Medicare	\$28.27	\$87.41	\$95.72	\$29.10
3 or more on Medicare	\$0.00	\$0.00	\$0.00	\$0.00
3 or more not on Medicare	\$34.69	\$112.08	\$119.24	\$35.71
3 or more not on Medicare and 1 on Medicare	\$34.69	\$90.20	\$100.29	\$35.71

## Dental Premiums July 1, 2010 through June 30, 2011

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$25.12	\$23.10	\$26.93
2 Persons	\$50.24	\$46.21	\$59.24
3 or More Persons	\$50.24	\$46.21	\$72.71

# Your 2010-2011 Premium Share

## Monthly Medical Premiums July 1, 2010 through June 30, 2011

Medical plan options with no retiree premium share:

Point of Enrollment - Gatekeeper Plans	Point of Enrollment Plans	Out-of-Area Plans
Anthem State BlueCare POE Plus UnitedHealthcare Oxford HMO	Anthem State BlueCare POE UnitedHealthcare Oxford HMO Select	UnitedHealthcare Oxford USA Out of Area plan Anthem Out-of-Area plan

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS
1 Person on Medicare	\$0.00	\$0.00
1 Person not on Medicare	\$12.85	\$13.23
1 Person not on Medicare and 1 on Medicare	\$12.85	\$13.23
1 not on Medicare and 2 on Medicare	\$12.85	\$13.23
2 on Medicare	\$0.00	\$0.00
2 not on Medicare	\$28.27	\$29.10
2 not on Medicare and 1 on Medicare	\$28.27	\$29.10
3 or more on Medicare	\$0.00	\$0.00
3 or more not on Medicare	\$34.69	\$35.71
3 or more not on Medicare and 1 on Medicare	\$34.69	\$35.71

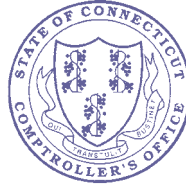
## Dental Premiums July 1, 2010 through June 30, 2011

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$25.12	\$23.10	\$26.93
2 Persons	\$50.24	\$46.21	\$59.24
3 or More Persons	\$50.24	\$46.21	\$72.71

*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](http://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](http://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.

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



2010-2011

For State of Connecticut



# Retirees

**Important Information About Your Benefits**

# Important Information About Your Benefits

PRESORTED  
FIRST-CLASS MAIL  
U.S. POSTAGE  
**PAID**  
NEW HAVEN, CT  
PERMIT NO. 344

Healthcare Policy & Benefit Services Division  
Office of the State Comptroller  
55 Elm Street  
Hartford, CT 06106-1775

