For State of Connecticut

Employees

HEALTH CARE OPTIONS PLANNER

2012-2013

A Message from
State Comptroller Kevin Lembo

How you live your life every day affects your health and what you pay out of pocket for your health care. Even if you're happy with your current coverage, it's a good idea to review the plans each year during open enrollment.

All of the State of Connecticut medical plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

During this open enrollment, if you have not previously enrolled in the Health Enhancement Program (HEP), you must decide if you want to participate in HEP for 2012-2013. HEP is designed to help you and your family work with your medical providers to make the best decisions about your health.

If you want to enroll in HEP, you must do so by May 31, 2012 or you will not be allowed to participate in HEP until the next open enrollment.

Those who participated in HEP during 2011-2012 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2012-2013 and will continue to pay lower premiums for their health care coverage.

Please take a few minutes 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 health care.

Kevin Lembo
State Comptroller
April 2012

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What You Need to Do

Current Employees

Open Enrollment Is Now Through May 31, 2012

Open enrollment is May 1-31, 2012. Now is your opportunity to adjust your health care 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 plan option for you. For 2012 Open Enrollment information, please go to the Comptroller's website at www.osc.ct.gov or check with your personnel office.

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

If you'd like to make a change for 2012-2013, contact your agency personnel or payroll office to request a Benefit Enrollment Form.

New Employees

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 (available from Human Resources).
3. Return the form within 31 calendar days of the date you were hired.

If you enroll as a newly hired employee, your coverage begins the first day of the month following your hire date. For example, if you're hired on October 15, your coverage begins November 1.

The elections you make now are effective through June 30, 2013 unless you have a qualifying status change (see page 3).

Who's Eligible

It's important to understand who you can cover under the plan. It's critical that the State is providing coverage only for those who are eligible under the rules of the plan.

Eligible dependents generally include:

- Your legally married spouse or civil union partner;
- Your children, including stepchildren and adopted children, up to age 26 for medical and age 19 for dental;
- Children for whom you are legal guardian up to age 18 unless proof of continued dependency is provided therefore allowing coverage up to age 26.

Disabled children may be covered beyond age 26, with proper documentation from the medical insurance carrier.

Documentation of an eligible relationship is required when you enroll a family member. It is your responsibility to notify your Agency Human Resources Office when any dependent is no longer eligible for coverage.

There are recent clarifications to dependent eligibility. Refer to www.osc.ct.gov for details.

Make Sure You Cover Only Eligible Dependents

As your children get older or your family situation changes, be sure you consider whether the people you have covered under the plan are still eligible. It can be a costly oversight if you continue to cover an ineligible person.

Did your child reach age 19? Once your child is 19, they are no longer eligible for dental benefits (unless disabled).

Did your child reach age 26? Once your child is 26, they are no longer eligible for medical and pharmacy benefits (unless disabled).

If you are covering someone who is **not** an eligible dependent, you will have to pay federal and state tax on the fair market value of benefits provided to that individual.

No later than July 1, 2012 – In preparation for an upcoming dependent audit, you must identify if you are providing coverage for:

- A former spouse from whom you are legally separated or divorced;
- Any individual between the ages of 18 and 26 for whom you were a legal guardian and who is not your "child" as defined above.

Please refer to the Comptroller's website at www.osc.ct.gov for recent clarifications to dependent eligibility.

Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes July 1, 2012 – June 30, 2013 unless you experience a qualifying status change. If you do have a qualifying status change, you must notify Human Resources within 31 days of the event. The change you make must be consistent with your change in status.

Please call Human Resources 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 Human Resources. 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).

This planner provides a brief summary of covered expenses. See Your Benefit Resources on page 26 to receive more detailed information.

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
Annual Deductible	HEP Enrollees: None Non-HEP Individual: $350 Non-HEP Family: $350 each member ($1,400 maximum)		Individual: $300 Family: $900
Annual Out-of-Pocket Maximums	HEP Enrollees: None Non-HEP Individual: $350 Non-HEP Family: $350 each member ($1,400 maximum)		Individual: $2,000 (plus deductible) Family: $4,000 (plus deductible)
Lifetime Maximum	None		None
Coinsurance	None		You pay 20% of allowable charge plus*
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$15 co-pay		80%
Preventive Care	No co-payment for preventive care visits and immunizations		80%
Family Planning Oral Contraceptives - Rx plan	Covered on same basis as other prescription drugs		Covered on same basis as other prescription drugs
Vasectomy	100% (prior authorization may be required)		80% (prior authorization may be required)
Tubal Ligation	100% (prior authorization may be required)		80% (prior authorization may be required)
Inpatient Physician	100% (prior authorization required)		80% (prior authorization required)
Inpatient Hospital	100% (prior authorization required)		80% (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)		80% (prior authorization required)
Ambulance	100% (if emergency)		100% (if emergency)
Pre-admission Authorization/ Concurrent Review	Through participating provider		Penalty of 20% up to $500 for no authorization
Mental Health	Prior authorization required		Prior authorization required
Inpatient	100%		80%
Outpatient	$15 co-pay (prior authorization required after 20 visits)		80% (prior authorization required after 20 visits)
Substance Abuse	Prior authorization required		Prior authorization required
Detoxification	100%		80%
Inpatient	100%		80%
Outpatient	$15 co-pay		80%
Skilled Nursing Facility	100% (prior authorization required)		80%, up to 60 days/year (prior authorization required)
Home Health Care	100% (prior authorization may be required)		80%, up to 200 visits/year (prior authorization may be required)
Hospice	100% (prior authorization required)		80%, up to 60 days (prior authorization required)
Short-Term Rehabilitation and Physical Therapy	100% (prior authorization may be required)		80%, up to 60 inpatient days, 30 outpatient days per condition per year (prior authorization may be required)
Diagnostic X-Ray and Lab	100% (prior authorization required for diagnostic imaging)		80% (prior authorization required for diagnostic imaging)
Pre-Admission Testing	100%		80%
Emergency Care	$35 co-pay		$35 co-pay
Durable Medical Equipment	100% (prior authorization may be required)		80% (prior authorization may be required)
Prosthetics	100% (prior authorization may be required)		80% (prior authorization may be required)
Routine Eye Exam	$15 co-pay, 1 exam per year		50%, 1 exam per year
Audiological Screening	$15 co-pay, 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.

Health Enhancement Program

The Health Enhancement Program (HEP) has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your health care. Third, it will save money for the state long term by focusing our health care dollars on prevention. It's your choice whether or not to participate, but there are many advantages to doing so.

You Save Money by Participating!

When you and all of your enrolled family members participate in HEP, you will pay lower monthly premiums and have no deductible for in-network care for the plan year. If one of you has one of the five chronic conditions identified on page 6, you may also receive a $100 payment, provided you and all enrolled family members comply with HEP requirements. You also save money on prescription drugs to treat that condition (see page 6).

HEP encourages employees and enrolled family members to take charge of their health and health care by following health guidelines defined by the Program.

If You Do Not Enroll in HEP

Unless you enroll in HEP, your premiums will be $100 per month higher and you will have an annual $350 per individual ($1,400 per family) in-network medical deductible.

For employees enrolled in Family Less Employed Spouse (FLES): to participate in HEP, both employees must enroll.

How to Enroll in HEP

For those who are not currently participating in HEP, forms are available at your agency Payroll/Human Resources office or by visiting the Office of the State Comptroller website, www.osc.ct.gov.

Those who participated in HEP during 2011-2012 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2012-2013 and will continue to pay lower premiums for their health care coverage.

Health Enhancement Program Requirements

Each year, you and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams).

Those enrolled in the dental plan must also get annual dental cleanings. All of the plans cover up to two cleanings per year. If you are enrolled in HEP up to two dental cleanings and two periodontal maintenance sessions are covered at 100% each year. And, periodontal care is unlimited but cost shares may still apply.

Additional Requirements for Those With Certain Conditions

If you or any of your enrolled family members have **1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure),** you or that family member may be required to participate in a disease education and counseling program for that particular condition. They will receive free office visits and reduced pharmacy co-pays for treatments related to their condition (see Your Prescription Drug Coverage at a Glance for cost details).

These particular conditions are targeted because they account for a large part of our total health care costs and have been shown to respond particularly well to disease education and counseling programs. By participating in these programs, affected employees and family members will be given additional resources to improve their health.

Frequently Asked Questions

1. *By joining HEP, will my family and I have access to the same network of doctors and health care practitioners?*

Yes, the network of participating providers is the same whether or not you participate in HEP.

2. *If I participate in HEP, will the state have access to my private health care information?*

No. All claim and diagnosis data is kept strictly confidential, and will only be reviewed by the health insurance carrier to ensure you follow the HEP requirements.

3. *If I don't follow the HEP requirements, what will happen?*

If you do not get required tests or screenings, or participate in the disease counseling and education program for your chronic condition, if applicable, you will be given appropriate notice and opportunity to meet HEP requirements. You may be removed from HEP and required to pay an increased premium and an in-network deductible for the next year.

4. *If I participate in the disease education and counseling program but my health condition gets worse, will I be removed from HEP?*

Not at all! HEP is designed to enhance the patient's ability to work with their doctors to make the most informed decisions about staying healthy, and, if ill, to treat their illness. The purpose of the disease education and counseling program is to encourage healthy behaviors. Whether or not your condition actually improves or gets worse will not affect your eligibility to continue participating and receiving the financial discounts.

Making Your Decision

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your payroll deduction 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 benefits 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 4.)
2. **Cost** – what you pay when you receive medical care and what is deducted from your paycheck. What you pay at the time you receive services is similar across the plans (see the chart on page 4). However, your payroll deduction varies quite a bit (see page 25).
3. **Networks** – whether your provider or hospital has contracted with the insurance carrier. (See page 11.)
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 9 – 11).

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 were first hired 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 health care 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 health care services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Getting your care within the network provides the highest benefit level:

- If you choose a **Point of Enrollment (POE)** plan, you must use in-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. Your in-network co-pays are also higher under a POS plan than under a POE or POE-G plan.
- If you choose a **Point of Enrollment - Gatekeeper (POE-G)** plan, you must use in-network providers for your care (except in emergencies) and you must obtain a referral for most specialist care.

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 to provide you with nationwide access to the highest level of benefits.

- Thinking of retirement and planning to 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 health care services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

Point of Enrollment (POE) Plans – These plans offer health care 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. Health care services obtained outside the network may not be covered.

Point of Enrollment – Gatekeeper (POE-G) Plans – These plans offer health care 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.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 26).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 26).

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 prior authorization 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 prior authorization (see page 4), 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 health care 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 provide you access to out-of-network providers when you pay more of the fees. Some require you to select a Primary Care Physician (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** – Both insurance carriers offer discounts to members for certain health-related expenses such as gym memberships and eyeglasses.

	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

Your Plan Options From Anthem

	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 Co-pay	$15*	$15*	$15*	$15*
Specialist Co-pay	$15*	$15*	$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 co-pays 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.

Service: working to exceed your expectations

We've been in Connecticut for more than 75 years, and we've been serving State of Connecticut employees and retirees for more than 50 of those years. This means we know your needs, and we're ready and able to help. Get answers and information through our:

- **State-dedicated Member Services Unit at 800-922-2232:** Talk with a customer service expert who is located right here in the state and is dedicated solely to State employees and retirees.
- **State-dedicated website at anthem.com/statect:** Find information geared specifically to you and other State employees and retirees.

24/7 NurseLine

You can call the toll-free number — **800-711-5947** — to talk with a nurse about your general health questions any time of the day or night. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. Our nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do.

You can also listen to recorded messages on hundreds of health topics. Just call the 24/7 NurseLine number and choose the Audio-Health Library option.

Wellness: supporting and guiding you

Lose weight. Join a gym. Control asthma. When it comes to our health, we all have different goals. That's why we have a full range of wellness programs, online tools and resources designed to meet your unique needs.

[1] Anthem Health and Wellness Program Satisfaction Study.

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Service. Wellness. Better health.

Customer service that's focused on your needs. Wellness programs that support and guide you. Plans that promote better health. Your health care plan should fit into your personal plan.

360° Health®

From finding an answer to a common health question to getting one-on-one support for a chronic health condition, you can get the help you need through our 360° Health program. Here's a sampling of what's available to you by accessing the State dedicated website at anthem.com/statect:

- **Future Moms:** Expecting moms can talk with nurses about pregnancy-related concerns. These moms-to-be also receive information to help them prepare for baby and track their pregnancy week by week.
- **ConditionCare:** If you have a chronic condition like asthma, diabetes, heart failure, coronary artery disease, or chronic obstructive pulmonary disease, you know how important it is to take care of yourself — everyday. This program teams you up with a nurse and other professionals. You'll gain a better understanding of your health, receive help following your doctor's care plan and learn to better manage your condition.
- **ComplexCare:** If you're living with multiple medical conditions, you may need a little extra support. With this program, personal nurse coaches help you create personalized goals and stay on track with your doctor's treatment plans. They can also pinpoint and refer you to other 360° Health programs.

SpecialOffers@Anthem℠

As a State employee or retiree, you can get discounts on products that encourage a healthy lifestyle. You'll get "healthy discounts" on things like:

- Weight loss programs through Weight Watchers®, Jenny Craig® and more
- Fitness club memberships, equipment and coaching
- Hearing aids
- Allergy products
- Acupuncture
- Massage therapy
- Baby safe gear
- Senior Care services

Better health: getting the most from your benefits

Your health plan should do more than just help you when you're sick. It should help you be your healthiest. That's why Anthem plans include things like vision benefits and large nationwide networks. So you can get more health from your health care.

Vision

The Anthem plans for the State of Connecticut include vision coverage and discounts:

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 and 20% on nonprescription sunglasses, and get discounts on exams. Choose from private practice or retailer providers including LensCrafters®, Target® Optical, Sears Optical, JCPenney Optical and most Pearle Vision® locations.
- **TruVision™** – Pay just $895 to $1,895 per eye on LASIK laser vision correction or receive 15-20% discounts and free shipping on contact lens orders.

LCA Vision

Save 15% on LASIK when you use a provider in the Premier Lasik Network, one of the largest surgeon networks in the country. Pay as little as $695 per eye when you use one of their "select" providers.

Have a question? Call our State-dedicated Member Services Unit at 800-922-2232. We're ready to help you. You'll also find good information at anthem.com/statect.

Network access

Anthem provides expansive coverage nationally and around the world. Through the BlueCard® program, you can use the networks of other Blue Cross and Blue Shield plans, so you can get the care you need — just about anywhere you travel. We can help you find the right care locations outside of Connecticut by calling 800-810-BLUE.

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.

Grow healthy. Live well.

If you haven't considered UnitedHealthcare before, this is the year to do it. It's the smart choice, and here are five reasons why:

1: Cost Savings
When you choose UnitedHealthcare, you can save premium dollars throughout the year. And that's not even counting the cost savings you get through our discount programs such as UnitedHealth Allies. Additional savings are yours on vision, dental and wellness needs, as well as products for diabetics, fitness equipment and nutrition.

2: Network
A robust national and local network means your doctor is likely already in it. Nationally, and in the tri-state area, we have a vast number of physicians, healthcare professionals and hospitals.

3: Dental
You may already have our dental coverage, but we have medical coverage too.

4: Trust
We have been serving state employees and their families for seven years.

5: Tools
Everything you need at your fingertips 24/7. Search for a doctor, view your claims, check your account balances, online health coaching and much more.

Oxford On-Call

Health care guidance, 24 hours a day

General health information
Oxford On-Call can give you helpful information about many topics. Call about illness, injury, chronic conditions, prevention, healthy living, and men's, women's and children's health.

Deciding where to go for care
Not sure if your situation calls for a doctor visit? Wonder if you should go to an after-hours urgent care clinic or the emergency room? Oxford On-Call's nurses provide information that can help you access care that is appropriate for your situation.

HEALTH CARE GUIDANCE, 24 HOURS A DAY:

If you are a member and you need to reach Oxford On-Call, please call **800-201-4911. Press option 4.**

Choosing self-care measures

Registered nurses provide practical self-care tips to help you manage your condition at home. Nurses can also tell you about signs and symptoms that may indicate the need for a higher level of care.

Communicating with your healthcare provider

Make the most of your doctor visits. Call Oxford On-Call before you go to your appointment, and a nurse can help you make a list of questions to ask your doctor.

Guidance for difficult decisions

If you or a family member has a serious medical condition, Oxford On-Call nurses can be a great resource.

Learn more about medical conditions, the possible risks and benefits of treatment options and information to help you take medications safely. The more you know, the better prepared you'll be.

Health Information Library

Listen to more than 1,100 recorded messages on health and well-being topics. To access the library, call the Oxford On-Call telephone number, and choose the option for Health Information Library. Then, press or say "5" and enter PIN number 123. You can ask a nurse about the topics and code numbers.

Live Web chat

Nurses are available to chat online about a variety of health topics and to confidentially guide you to online resources.

Frequently asked questions

Q: What Labs are in the UnitedHealthcare/Oxford network?

A: UnitedHealthcare/Oxford has an extensive network of participating laboratory facilities all across Connecticut, including Clinical Laboratory Partners, Collaborative Lab Services and Laboratory Corp. of America (LabCorp), just to name a few. There are numerous other individual labs across our network, including many hospital labs, which you can easily find by visiting **www.welcometouhc.com/stateofct,** or by calling our State of Connecticut designated Customer Service team at **800-385-9055** (for members), or **800-760-4566** (for prospective members).

Q: Did you know that our Connecticut network continues to grow?

A: State of Connecticut members have access to UnitedHealthcare/Oxford's robust network within the Connecticut, New York and New Jersey tri-state areas, and seamless access to our national Choice Plus network.

Through tireless efforts, our Network Management team has been able to add quite a few new providers over the last 18 months, including some of the larger physician groups such as Internal Medicine of Milford and Johnson Professional Associates in Stafford Springs. We have also added two groups specifically requested by State of Connecticut members: The Plainfield Walk-In Center and Linden, Thompson, Cooper and Goldberg in Niantic.

It may also be of note to you to know that we have the physicians at the UCONN Student Health Center in Storrs, Connecticut in our network!

Q: What if I need to access care outside of Connecticut?

A: As a UnitedHealthcare/Oxford member, you have seamless access to our local network in New York and New Jersey, in addition to Connecticut, even on the Point-of-Enrollment (POE) and Point-of-Enrollment Gatekeeper (POE-G) plans. Please keep in mind that on the POE-G plan, you are required to obtain a referral from your primary care physician to seek services from participating specialists.

In addition to our local network of Connecticut, New York and New Jersey, you also have access to a large national network of providers utilizing the UnitedHealthcare Choice Plus network. This opens up an entire nation of participating providers to you, whether you are traveling, your dependent attends college out of the local area or you live out of the service area on the Out-of-Area (Oxford USA) plan. You can access our nationwide UnitedHealthcare Choice Plus network by visiting our website, **www.welcometouhc.com/stateofct,** and signing in to your account, or by calling our State of Connecticut designated Customer Service team at **800-385-9055.**

If you are not yet a UnitedHealthcare/Oxford member, and wish to search our network, you can do so by visiting **https://www.geoaccess.com/uhc/po/Default.asp.** When asked to select the plan, choose "UnitedHealthcare Choice Plus". You may also call our designated State of Connecticut Customer Service team at **800-760-4566** (for prospective members).

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 26.

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

No, as long as you work in Connecticut, you do not need to choose an Out-of-Area plan.

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.

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 26. It's likely your doctor is covered by more than one network.

Can I enroll later or switch plans mid-year?

The elections you make now are in effect through June 30, 2013. 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.

Q&A

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.

I am a 65-year-old active state employee. Which health plan card should I present to a doctor's office or hospital?

When visiting a doctor or hospital, present your State of Connecticut employee plan health card (not your Medicare card). Since you are still working, your employer coverage is your primary health insurance provider; Medicare is secondary.

My spouse is covered under my state medical plan and will soon be eligible for Medicare. Should he sign up for Medicare? What else does he need to do?

As long as you are enrolled in health insurance coverage as an active employee and your spouse remains covered under your state plan, the state plan is primary and Medicare is secondary for your spouse. This means that Medicare will only pay for services after your employee plan has made its payment.

Because your spouse has coverage through the state plan, there is no need to take action right away. He can sign up for Medicare parts A and B during a later Medicare enrollment period with no penalty while still covered under the state plan or for a limited time after dropping or otherwise losing state coverage.

For information on Medicare, visit www.medicare.gov.

Your Prescription Drug Coverage at a Glance

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

Maintenance Medications

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long term.

The plan has a 3-tier co-pay 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.

PRESCRIPTION DRUG CO-PAYS ARE AS FOLLOWS:

For...	Maintenance Drugs 90-Day Supply	Non-Maintenance Drugs 30-Day Supply
Tier 1: Generic drug	$5	$5
Tier 2: Preferred brand-name drug	$10	$20
Tier 3: Non-preferred brand-name drug	$25 ($10 if your physician certifies the non-preferred brand-name drug is medically necessary)	$35 ($20 if your physician certifies the non-preferred brand-name drug is medically necessary)

For those enrolled in the Health Enhancement Program, medications used to treat chronic conditions covered by HEP's disease education and counseling programs cost even less:

- $0 co-pay for Tier 1 (generic)
- $5 co-pay for Tier 2 (preferred)
- $12.50 co-pay for Tier 3 (non-preferred).

There is $0 co-pay for medications and supplies used to treat diabetes (Type 1 and Type 2).

To check which co-pay amount applies to your prescriptions, visit 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 co-pay 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 www.osc.ct.gov) and fax it to Caremark. If approved, you will pay the preferred brand co-pay 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 on page 18, 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 co-pay 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.

Mandatory 90-day Supply for Maintenance Medications

If you or your family takes a maintenance medication, you will be able to get your first 30-day fill of that medication at any participating pharmacy. After that your two choices are:

- Receive your medication through the Caremark mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the state's new Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

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 1-800-237-2767 for information.

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%	Covered**
Oral Surgery	Covered at 67%	Covered at 67%	Covered**
Major Restoration Crowns	Covered at 67%	Covered at 67%	Covered**
Dentures, Fixed Bridges	Not covered	Covered at 50%	Covered**
Orthodontia	Not covered	Plan pays $1,500 per person per lifetime	Covered**

* If enrolled in the Health Enhancement Program: Up to two dental cleanings and two periodontal maintenance sessions are covered at 100% each year. Periodontal care is unlimited but cost shares may still apply.

** Contact CIGNA at 1-800-244-6224 for patient co-pay amounts.

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. However, your out-of-pocket expenses may be higher if you see an out-of-network provider.

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 $200, your dentist may 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.)

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

Comparing Your Plans: A Message From UnitedHealthcare Dental

Overview of UnitedHealthcare Dental® benefits

How do I know which plan is best for me?

We realize that one plan does not fit all so we've created two plans to choose from: the Enhanced Plan and the Basic Plan. With both plans you have access to in- and out-of-network dentists. **However, you may have lower out-of-pocket costs when you visit a participating network dentist. To learn more, compare the options below.**

Basic Plan

- You can visit any dentist or dental specialist, without a referral
- Preventive services covered at 80%, including oral cancer screening
- HEP enrollees covered at 100% for 2 cleanings per year
- No deductibles

Enhanced Plan

- Flexibility to seek care outside of the network with higher out-of-pocket member costs. Non-network payments are paid at the maximum allowable charge (MAC)
- Realize cost savings per procedure by utilizing a network dentist or specialist
- All preventive services covered at 100% in network, including oral cancer screening
- Coverage for orthodontics, bridges and dentures for adults and children

Prenatal Dental Care Program for Enhanced and Basic plans

Taking care of your teeth and gums during pregnancy is an important part of your and your unborn child's good health. Gum disease and periodontal disease (related to tooth-support structures) during pregnancy has been linked to an increased risk of pre-term and very pre-term delivery.

That's why we created a UnitedHealthcare Dental program, which provides additional network preventive dental care coverage for expectant mothers. If you are in your second or third trimester of pregnancy, you are eligible for this program's benefits as part of your benefit plan.

To use this benefit:

- Visit any dentist: Tell the dentist you're pregnant and how far along you are and your due date
- Inform your dentist of any prescribed medications
- Make sure the dentist waives the eligible fees (for cleanings, deep scalings, periodontal maintenance and removing dead or infected tissue)
- Most important: Remind the dentist to include the following on the claim form: Your due date and your attending physician's or obstetrician's name

Key cost-savings and benefits:

- No out-of-pocket costs for network services, as described†
- Fees are not applied to the benefit period maximum
- Fees are not applied to deductibles
- Waiting Periods do not apply if services are required by a network dentist
- No referral needed

If you have any questions, call customer service at **800-896-4834** or visit **www.myuhcdental.com/statect.**

† For indemnity plans or PPO plans with out-of-network options, fees are set to maximum allowable charges.

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.

Comparing the Basic and Enhanced Plans

UnitedHealthcare offers State of Connecticut members and retirees two dental plans: UnitedHealthcare Dental® Enhanced Plan or UnitedHealthcare Dental® Basic Plan.

			ENHANCED DENTAL PLAN			
	Basic Dental Plan	**Basic Dental Plan with HEP**	**Network**	**Network with HEP**	**Out-of-Network**	**Out-of-Network with HEP**
Calendar year deductible (waived for preventive and diagnostic); does not apply to orthodontics	Not applicable	Not applicable	$25 individual/ $75 family		$25 individual/ $75 family	
Calendar year maximum (combined for network and out-of-network); does not apply to orthodontics	Not applicable	Not applicable	$3,000		$3,000	
Periodontics annual maximum	$500 per calendar year	Annual maximum waived for certain periodontal procedures	Included with calendar year maximum **waived on certain procedures for HEP enrollees**		Included with calendar year maximum **waived on certain procedures for HEP enrollees**	
Cleanings	80%	100%	100% network only	100% network only	100% of MAC	100% of MAC
Sealants	Not covered	Not covered	100% network only	100% network only	100% of MAC	100% of MAC
Orthodontics lifetime maximum (combined for network and out-of-network)	Not applicable	Not applicable	$1,500		$1,500	
Consumer MaxMultiplier℠	Not applicable	Not applicable	Yes		Yes	
Prenatal Dental	Yes	Yes	Yes		Yes	

IMPORTANT INFORMATION TO KNOW ABOUT YOUR HEP BENEFITS

- Full coverage for cleanings and exams (2 per year) and bitewing x-rays (1 per year) under the Basic and Enhanced plans. Note: Under the Enhanced plan you must use an in network dentist to receive 100% coverage.
- No annual maximum on services for periodontal maintenance (2 per year) or scaling and root planing (frequency limits and applicable cost shares still apply).

Comparing Your Plans: A Message From CIGNA

Why enroll in the CIGNA Dental Care® (DHMO[1])?

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

www.cigna.com • 1.800.CIGNA24 (1-800-244-6224)

The **Importance** of Good Oral Care

Did you know that most preventive dental care has $0 or low co-pay 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

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.[2] 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.**®

With this program, eligible customers with certain conditions may receive 100% reimbursement of their co-pay 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
- Orthodontia treatment for children (up to 19th birthday) **and** adults.

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 Cigna DHMO is **Easy to Use**

Your Patient Charge Schedule (SCT07) will list all of the covered procedures under your plan and the amount you'll pay (co-pays) for each. A few examples of covered procedures (with co-pays) include:

COVERED PROCEDURE	CO-PAY AMOUNT
X-Rays	$0
Cleanings (2 per calendar year)	$0
Amalgam Filling (1 Surface)	$5.00
Resin-Based Composite Filling (1 Surface, Posterior)	$42.00
Porcelain/Ceramic Crown	$450.00
24-Month Comprehensive Orthodontic Treatment Fee for Children	$3,139.00
24-Month Comprehensive Orthodontic Treatment Fee for Adults	$3,811.00

Review your enrollment kit materials carefully before you enroll.

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

Visit our **DHMO-Specific Website** Designed Just for State of CT Employees

Go to **http://www.cigna.com/stateofct** to access the following:

- Your Patient Charge Schedule
- DHMO brochures
- DHMO FAQ
- Instructions on how to find a dentist
- DHMO decision guide
- Customer service contact numbers
- Links to gum disease and cavity risk assessment tools
- Links to Cigna.com and myCigna.com
- Dental health flyers

Everything you'll want to know about the Cigna DHMO is now just a mouse click away. So, check out the site to see if the Cigna DHMO is the right plan for you and your family.

Remember to select a primary care dentist when enrolling in the DHMO

When you enroll in the Cigna DHMO, it is required that you select a general dentist from our DHMO network. This dentist will handle all of your dental care needs and refer you to a network specialist when necessary. As part of the DHMO, you can also designate a primary network general dentist for your covered dependents that is different from your dentist.

Since the Cigna DHMO is an in-network plan only, note that the general dentist you select is the one you'll need to visit for treatment. Procedures won't be covered if you visit a dentist not in the Cigna DHMO Network.

Important Note: UConn Health Center is part of the Cigna DHMO Network.

Cigna and the Health Enhancement Program (HEP)

If enrolled in the HEP, remember to get your required annual preventive care cleanings.

If you have questions about the HEP, please call Cigna Customer Service 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.[3]
- **Find** and change network dentist offices.[4]
- **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.

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[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. 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.

[2] www.ada.org, November 2004.

[3] 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.

[4] 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 2012-2013 Payroll Deductions

Health Enhancement Program Bi-Weekly Payroll Deductions July 1, 2012 through June 30, 2013 (26 Pay Periods)

If you do not enroll in the Health Enhancement Program, an additional $46.16 will be deducted from your paycheck bi-weekly.

(Employees on semi-monthly pay schedules will have slightly higher deductions.)

MEDICAL PLANS	EMPLOYEE	EMPLOYEE +1	FAMILY	FLES**
Point of Enrollment – Gatekeeper Plans (POE-G)				
Anthem State BlueCare POE Plus	$23.43	$67.76	$87.06	$45.56
UnitedHealthcare Oxford HMO	$17.43	$49.92	$64.14	$33.57
Point of Enrollment Plans (POE)				
Anthem State BlueCare	$25.74	$77.54	$103.22	$51.81
UnitedHealthcare Oxford HMO Select	$20.53	$61.86	$82.34	$41.33
Point of Service Plans (POS)				
Anthem State BlueCare	$33.19	$114.66	$132.48	$59.41
Anthem State Preferred POS*	$79.38	$231.84	$272.49	$158.94
UnitedHealthcare Oxford Freedom Select	$26.93	$93.04	$107.50	$48.21
Out of Area Plans (OOA)				
Anthem OOA	$33.19	$114.66	$132.48	$59.41
UnitedHealthcare Oxford USA	$26.93	$93.04	$107.50	$48.21
DENTAL PLANS				
UnitedHealthcare Basic	$0.00	$13.08	$13.08	$6.70
UnitedHealthcare Enhanced	$0.00	$12.03	$12.03	$6.16
Cigna DHMO®	$0.00	$4.29	$6.07	$2.50

* Closed to new enrollment.

** The Family Less Employed Spouse (FLES) rate is available only when both spouses are employed by the State of Connecticut, eligible for health insurance, and enrolled in the same plan, along with at least one child.
For employees enrolled in FLES: to participate in the Health Enhancement Program, both employees must enroll.

All of the medical plans offered to State of Connecticut employees cover the same health care services. Saving a little each pay period can save you a lot each year.

- $5 each pay period saves you ..... $130 per year
- $10 each pay period saves you ..... $260 per year
- $50 each pay period saves you ..... $1,300 per year
- $75 each pay period saves you ..... $1,950 per year
- $110 each pay period saves you ..... $2,860 per year
- $150 each pay period saves you ..... $3,900 per year

Your Benefit Resources

For details about specific plan benefits and network providers, contact the insurance carrier. If you have questions about eligibility, enrolling in the plans or payroll deductions, contact your agency benefits office.

Anthem Blue Cross and Blue Shield • Anthem State Preferred POS (POS)* • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area	**www.Anthem.com/statect**	**1-800-922-2232**	
UnitedHealthcare (Medical) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford USA Out-of-Area	**www.welcometouhc.com/stateofct**	**1-800-385-9055**	
Caremark (Prescription drug benefits, any medical plan)	**www.Caremark.com**	**1-800-318-2572**	
UnitedHealthcare (Dental) • Basic Plan • Enhanced PPO	**www.Myuhcdental.com/statect**	**1-800-896-4834**	
CIGNA • DHMO Plan	**www.Cigna.com**	**1-800-244-6224**	

* Closed to new enrollment.