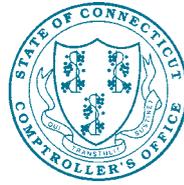


For State of Connecticut



# Retirees

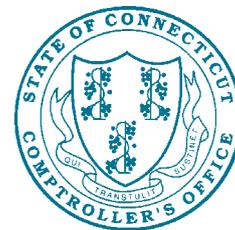


**HEALTH CARE OPTIONS PLANNER**

# 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.

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

# Table of Contents

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## 2012-2013 Plan Year News

If your retirement date is June 1, 1999 or later, the office visit co-pay is increasing to \$15 for POE, POE-G and out-of-area plans effective July 1, 2012.

There are no changes to premium share amounts for 2012-2013. Rates are listed on page 7, 11, 16 and 21 (depending on your retirement date).

HEP action required if  
your retirement date  
is October 2, 2011 or later.  
See page 19 for details.

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What You Need to Do .....	2
Current Retirees .....	2
New Retirees.....	2
Make Sure You Cover Only Eligible Dependents.....	3
Qualifying Status Change.....	3
Plan Summaries and Premium Shares	
<b>Group 1:</b> Retirement date prior to July 1997 .....	4
<b>Group 2:</b> Retirement date July 1, 1997 - May 1, 2009 (or retired under the 2009 Retirement Incentive Program) .....	8
<b>Group 3:</b> Retirement date June 1, 2009 - October 1, 2011.....	12
<b>Group 4:</b> Retirement date October 2, 2011 and later .....	17
Making Your Decision.....	22
Comparing Networks .....	23
Comparing Plan Features .....	25
A Message From Anthem.....	26
A Message From UnitedHealthcare .....	28
Frequently Asked Questions .....	30
A Message From UnitedHealthcare Dental.....	31
A Message From CIGNA.....	33
Enrollment Form .....	35
Your Benefit Resources.....	37



# What You Need to Do

## Medicare Eligibility and Premium Reimbursement

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.) See pages 5, 9, 13 and 18 for information on prescription drugs for Medicare-eligible participants (depending on your retirement date).

### 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 2012-2013 Premium Share” pages are customized by group.

#### GROUP 1:

If your **retirement date is before July 1997**, see pages 4-7 for information that applies specifically to you.

#### GROUP 2:

If your **retirement date is between July 1, 1997 and May 1, 2009 (or you retired under the 2009 Retirement Incentive Program)**, see pages 8-11 for information that applies specifically to you.

#### GROUP 3:

If your **retirement date is between June 1, 2009 and October 1, 2011**, see pages 12-16 for information that applies specifically to you.

#### GROUP 4:

If your **retirement date is October 2, 2011 or later**, see pages 17-21 for information that applies specifically to you.

**For additional details, please go to the Comptroller’s website at [www.osc.ct.gov](http://www.osc.ct.gov) or check with the Retirement Health Insurance Unit at (860) 702-3533.**

## Current Retirees

### Open Enrollment Through May 31, 2012

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 2012-2013. The form must be postmarked by May 31, 2012. Any changes you make are effective July 1, 2012 through June 30, 2013 unless you have a qualifying status change. If you don’t want to make changes, you don’t need to do a thing; your current coverage will continue automatically at the rates listed on page 7, 11, 16 or 21 (as applicable).

### 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 CO-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.

## Make Sure You Cover Only Eligible Dependents

It's important to understand who you can cover under the plan. It's critical that the State only provide coverage for eligible dependents. **If you obtain coverage for a person who is not eligible, you will have to pay federal and state tax on the fair market value of benefits provided to that individual.**

Eligible dependents generally include: your legally married spouse or civil union partner and eligible children until age 26 for medical and age 19 for dental. Your "children" include your natural children, stepchildren, and adopted children. Children for whom you are the legal guardian may be eligible for coverage between the ages 18 and 26 provided proof of continued dependency is provided. Disabled children may be covered beyond age 26.

In preparation for an upcoming dependent audit, all retirees must report to the Retirement Health Insurance Unit if you are covering any of the following individuals:

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

There are recent clarifications to dependent eligibility. Please refer to the Comptroller's website at [www.osc.ct.gov](http://www.osc.ct.gov) for details.

It is your responsibility to notify the Retirement Health Insurance Unit within 31 days when any dependent is no longer eligible for coverage.

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**This planner provides a brief summary of covered expenses. See Your Benefit Resources on page 37 to receive more detailed information.**

.....

## Qualifying Status Change

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.

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 at (860) 702-3533. 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).

# 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>Lifetime Maximum</b>	None	None
<b>Coinsurance</b>	None	You pay 20% of allowable charge plus*
<b>Outpatient Physician Visits</b>	\$5 co-pay	80%
<b>Preventive Care</b>	No copayment for preventive care visits and immunizations	80%
<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%**	80%**
Tubal Ligation	100%**	80%**
<b>Inpatient Physician</b>	100% (prior authorization required)	80% (prior authorization required)
<b>Inpatient Hospital</b>	100% (prior authorization required)	80% (prior authorization required)
<b>Outpatient Surgical Facility</b>	100% (prior authorization required)	80% (prior authorization required)
<b>Ambulance</b>	100% (if emergency)	100% (if emergency)
<b>Pre-admission Authorization/ Concurrent Review</b>	Through participating provider	Penalty of 20% up to \$500 for no authorization
<b>Mental Health</b>	Prior authorization required	Prior authorization required
Inpatient	100%	80%
Outpatient	\$5 co-pay***	80%***
<b>Substance Abuse</b>	Prior authorization required	Prior authorization required
Detoxification	100%	80%
Inpatient	100%	80%
Outpatient	\$5 co-pay	80%
<b>Skilled Nursing Facility</b>	100% (prior authorization required)	80%, up to 60 days/year (prior authorization required)
<b>Home Health Care</b>	100%**	80%, up to 200 visits/year**
<b>Hospice</b>	100% (prior authorization required)	80%, up to 60 days (prior authorization 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%**	80%**
<b>Prosthetics</b>	100%**	80%**
<b>Routine Eye Exam</b>	\$15 co-pay, 1 exam per year	50%, 1 exam per year
<b>Audiological Screening</b>	\$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.

\*\* Prior authorization may be required.

\*\*\* Prior authorization required after 20 visits.

# Your Prescription Drug Coverage at a Glance

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. 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:

## NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	\$3	\$0	20% of prescription cost
Preferred Brand	\$6	\$0	20% of prescription cost
Non-Preferred Brand	\$6	\$0	20% of prescription cost

\* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a \$0 co-pay for maintenance drugs.

## MEDICARE-ELIGIBLE

SILVERSCRIPT	In-Network		Out-of-Network
	Acute and Maintenance Drugs	SILVERSCRIPT Mail Order	
Generic	\$3	\$0	20% of prescription cost
Preferred Brand	\$6	\$0	20% of prescription cost
Non-Preferred Brand	\$6	\$0	20% of prescription cost

\* You can get a \$0 co-pay for maintenance drugs by using the SilverScript Mail Order pharmacy.

## When You Become Eligible for Medicare

When you become eligible for Medicare, you will be automatically enrolled in the SilverScript program. Your prescription benefits stay the same but you use your SilverScript ID card for prescriptions instead.

When you are enrolled, you will receive more information. However, there are two key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- When you receive a letter from SilverScript giving you the chance to opt out or cancel your enrollment, don't do it. They are required to send you this letter but if you opt out, medical and prescription drug coverage for you and your dependents will terminate. You can just ignore it.
- If you receive a notice that you are required to pay a higher Medicare D premium, you must submit that notice to the Retirement Health Insurance Unit for reimbursement.
- If you receive your mail at a post office box, you must provide a street address to the Retirement Health Insurance Unit per Center for Medicare and Medicaid Services regulations.
- Do not enroll in an individual Medicare Part D prescription drug plan. Doing so would cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.

The State of Connecticut implemented an Employer Group Wrap Plan (EGWP) for Medicare-eligible retirees effective January 1, 2012. This plan is administered by Silverscript, a subsidiary of CVS/Caremark.

This means that Medicare-eligible retirees and/or dependents have been enrolled in a Group Medicare Part D Plan. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits will continue to be administered by CVS/Caremark until you become Medicare eligible.

### Your Prescription Drug Coverage at a Glance (continued)

### 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 previous page, 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 or SilverScript at 1-866-693-4624.

### 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% (network only)	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 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, 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 37.)

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

# Your 2012-2013 Premium Share

There is no premium share for medical plans.

## Monthly Dental Premiums July 1, 2012 through June 30, 2013

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$26.42	\$24.30	\$27.86
2 Persons	\$52.85	\$48.61	\$61.30
3 or More Persons	\$52.85	\$48.61	\$75.23



# 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>Lifetime Maximum</b>	None		None
<b>Coinsurance</b>	None		You pay 20% of allowable charge plus**
<b>Outpatient Physician Visits</b>	\$15 co-pay*		80%
<b>Preventive Care</b>	No copayment for preventive care visits and immunizations		80%
<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%***		80%***
Tubal Ligation	100%***		80%***
<b>Inpatient Physician</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Inpatient Hospital</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Outpatient Surgical Facility</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Ambulance</b>	100% (if emergency)		100% (if emergency)
<b>Pre-admission Authorization/ Concurrent Review</b>	Through participating provider		Penalty of 20% up to \$500 for no authorization
<b>Mental Health</b>	Prior authorization required		Prior authorization required
Inpatient	100%		80%
Outpatient	\$15 co-pay*†		80%†
<b>Substance Abuse</b>	Prior authorization required		Prior authorization required
Detoxification	100%		80%
Inpatient	100%		80%
Outpatient	\$15 co-pay*		80%
<b>Skilled Nursing Facility</b>	100% (prior authorization required)		80%, up to 60 days/year (prior authorization required)
<b>Home Health Care</b>	100%***		80%, up to 200 visits/year***
<b>Hospice</b>	100% (prior authorization required)		80%, up to 60 days (prior authorization 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%
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<b>Durable Medical Equipment</b>	100%***		80%***
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<b>Audiological Screening</b>	\$15 co-pay, 1 exam per year		80%, 1 exam per year

\* \$5 co-pay 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.

\*\*\* Prior authorization may be required.

† Prior authorization required after 20 visits.

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Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. 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:

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Generic	\$3	\$0	20% of prescription cost
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\* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a \$0 co-pay for maintenance drugs.

## MEDICARE-ELIGIBLE

Silverscript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	Silverscript Mail Order	
Generic	\$3	\$0	20% of prescription cost
Preferred Brand	\$6	\$0	20% of prescription cost
Non-Preferred Brand	\$6	\$0	20% of prescription cost

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When you are enrolled, you will receive more information. However, there are two key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

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If you are NOT Medicare eligible, your prescription benefits will continue to be administered by CVS/Caremark until you become Medicare eligible.

### Your Prescription Drug Coverage at a Glance (continued)

### 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 previous page, 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.

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## Your Dental Plan Choices at a Glance

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<b>Annual Maximum</b>	None (\$500 per person for periodontics)	\$3,000 per person (excluding orthodontics)	None
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<b>Simple Restoration</b>			
Fillings	Covered at 80%	Covered at 80%	Covered*
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Before starting extensive dental procedures for which the dentist's charges may exceed \$200, 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 37.)

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

# Your 2012-2013 Premium Share

## Monthly Medical Premiums July 1, 2012 through June 30, 2013

Medical plan options with no retiree premium share:

**Point of Enrollment - Gatekeeper Plans**

Anthem State BlueCare POE Plus  
UnitedHealthcare Oxford HMO

**Point of Enrollment Plans**

Anthem State BlueCare POE  
UnitedHealthcare Oxford HMO Select

**Out-of-Area Plans**

UnitedHealthcare Oxford USA Out of Area plan  
Anthem Out-of-Area plan

**Point of Service (POS) Plans for 7/1/97 - 6/1/99 Retirees**

Anthem State BlueCare POS  
Anthem State Preferred POS  
UnitedHealthcare Oxford Freedom Select POS

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, 2012 through June 30, 2013

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$26.42	\$24.30	\$27.86
2 Persons	\$52.85	\$48.61	\$61.30
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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>Lifetime Maximum</b>	None		None
<b>Coinsurance</b>	None		You pay 20% of allowable charge plus*
<b>Outpatient Physician Visits</b>	\$15 co-pay		80%
<b>Preventive Care</b>	No copayment for preventive care visits and immunizations		80%
Children			
Adults			
<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%**		80%**
Tubal Ligation	100%**		80%**
<b>Inpatient Physician</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Inpatient Hospital</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Outpatient Surgical Facility</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Ambulance</b>	100% (if emergency)		100% (if emergency)
<b>Pre-admission Authorization/ Concurrent Review</b>	Through participating provider		Penalty of 20% up to \$500 for no authorization
<b>Mental Health</b>	Prior authorization required		Prior authorization required
Inpatient	100%		80%
Outpatient	\$15 co-pay***		80%***
<b>Substance Abuse</b>	Prior authorization required		Prior authorization required
Detoxification	100%		80%
Inpatient	100%		80%
Outpatient	\$15 co-pay		80%
<b>Skilled Nursing Facility</b>	100% (prior authorization required)		80%, up to 60 days/year (prior authorization required)
<b>Home Health Care</b>	100%**		80%, up to 200 visits/year**
<b>Hospice</b>	100% (prior authorization required)		80%, up to 60 days (prior authorization required)
<b>Short-Term Rehabilitation and Physical Therapy</b>	100%		80%, up to 60 inpatient days, 30 outpatient days per condition per year
<b>Imaging (i.e., MRI or CAT)</b>	100% (prior authorization required)		80% (prior authorization required)
<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%**		80%**
<b>Prosthetics</b>	100%**		80%**
<b>Routine Eye Exam</b>	\$15 co-pay, 1 exam per year		50%, 1 exam per year
<b>Audiological Screening</b>	\$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.

\*\* Prior authorization may be required.

\*\*\* Prior authorization required after 20 visits.

# Your Prescription Drug Coverage at a Glance

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose.

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.

## NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	\$5	\$0	20% of prescription cost
Preferred Brand	\$10	\$0	20% of prescription cost
Non-Preferred Brand	\$25	\$0	20% of prescription cost

\* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a \$0 co-pay for maintenance drugs.

## MEDICARE-ELIGIBLE

Silverscript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	Silverscript Mail Order	
Generic	\$5	\$0	20% of prescription cost
Preferred Brand	\$10	\$0	20% of prescription cost
Non-Preferred Brand	\$25	\$0	20% of prescription cost

\* You can get a \$0 co-pay for maintenance drugs by using the Silverscript Mail Order pharmacy.

To check which co-pay 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 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 <http://www.osc.ct.gov/empret/indxhlth.htm>) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

The State of Connecticut implemented an Employer Group Wrap Plan (EGWP) for Medicare-eligible retirees effective January 1, 2012. This plan is administered by Silverscript, a subsidiary of CVS/Caremark.

This means that Medicare-eligible retirees and/or dependents have been enrolled in a Group Medicare Part D Plan. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits will continue to be administered by CVS/Caremark until you become Medicare eligible.

### Your Prescription Drug Coverage at a Glance (continued)

## When You Became Eligible for Medicare

If you are eligible for Medicare, you will be automatically enrolled in the SilverScript program. Your prescription benefits are the same but you use your SilverScript ID card for prescriptions instead.

When you are enrolled, you will receive more information. However, there are two key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- When you receive a letter from SilverScript giving you the chance to opt out or cancel your enrollment, don't do it. They are required to send you this letter but if you opt out, medical and prescription drug coverage for you and your dependents will terminate. You can just ignore it.
- If you receive a notice that you are required to pay a higher Medicare D premium, you must submit that notice to the Retirement Health Insurance Unit for reimbursement.
- If you receive your mail at a post office box, you must provide a street address to the Retirement Health Insurance Unit per Center for Medicare and Medicaid Services regulations.
- Do not enroll in an individual Medicare Part D prescription drug plan. Doing so would cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.

## 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 previous page, 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 or SilverScript at 1-866-693-4624.

## 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

	<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% (network only)	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 co-pay amounts.

Before starting extensive dental procedures for which the dentist's charges may exceed \$200, 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 37.)

## 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.

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

# Your 2012-2013 Premium Share

## Monthly Medical Premiums July 1, 2012 through June 30, 2013

Medical plan options with no retiree premium share:

### Point of Enrollment - Gatekeeper Plans

Anthem State BlueCare POE Plus  
UnitedHealthcare Oxford HMO

### Point of Enrollment Plans

Anthem State BlueCare POE  
UnitedHealthcare Oxford HMO Select

### Out-of-Area Plans

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, 2012 through June 30, 2013

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$26.42	\$24.30	\$27.86
2 Persons	\$52.85	\$48.61	\$61.30
3 or More Persons	\$52.85	\$48.61	\$75.23

# 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>	HEP Enrollees: None Non-HEP Individual: \$350 Non-HEP Family: \$350 each member (\$1,400 maximum)		Individual: \$300 Family: \$900
<b>Annual Out-of-Pocket Maximums</b>	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)
<b>Lifetime Maximum</b>	None		None
<b>Coinsurance</b>	None		You pay 20% of allowable charge plus*
<b>Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers</b>	\$15 co-pay		80%
<b>Preventive Care</b>	No co-payment for preventive care visits and immunizations		80%
<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% (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)
<b>Inpatient Physician</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Inpatient Hospital</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Outpatient Surgical Facility</b>	100% (prior authorization required)		80% (prior authorization required)
<b>Ambulance</b>	100% (if emergency)		100% (if emergency)
<b>Pre-admission Authorization/Concurrent Review</b>	Through participating provider		Penalty of 20% up to \$500 for no authorization
<b>Mental Health</b>	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)
<b>Substance Abuse</b>	Prior authorization required		Prior authorization required
Detoxification	100%		80%
Inpatient	100%		80%
Outpatient	\$15 co-pay		80%
<b>Skilled Nursing Facility</b>	100% (prior authorization required)		80%, up to 60 days/year (prior authorization required)
<b>Home Health Care</b>	100% (prior authorization may be required)		80%, up to 200 visits/year (prior authorization may be required)
<b>Hospice</b>	100% (prior authorization required)		80%, up to 60 days (prior authorization 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% (prior authorization required for diagnostic imaging)		80% (prior authorization required for diagnostic imaging)
<b>Pre-Admission Testing</b>	100%		80%
<b>Emergency Care</b>	\$35 co-pay		\$35 co-pay
<b>Durable Medical Equipment</b>	100% (prior authorization may be required)		80% (prior authorization may be required)
<b>Prosthetics</b>	100% (prior authorization may be required)		80% (prior authorization may be required)
<b>Routine Eye Exam</b>	\$15 co-pay, 1 exam per year		50%, 1 exam per year
<b>Audiological Screening</b>	\$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.

# Your Prescription Drug Coverage at a Glance

The State of Connecticut implemented an Employer Group Wrap Plan (EGWP) for Medicare-eligible retirees effective January 1, 2012. This plan is administered by Silverscript, a subsidiary of CVS/Caremark.

This means that Medicare-eligible retirees and/or dependents have been enrolled in a Group Medicare Part D Plan. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits will continue to be administered by CVS/Caremark until you become Medicare eligible.

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose.

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.

## NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network			Out-of-Network
	Acute Drugs	Maintenance Drugs*	HEP Enrolled (Maintenance Drugs to treat chronic condition)*	
Generic	\$5	\$5	\$0	20% of prescription cost
Preferred Brand	\$20	\$10	\$5	20% of prescription cost
Non-Preferred Brand	\$35	\$25	\$12.50	20% of prescription cost

\* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance drugs.

## MEDICARE-ELIGIBLE

Silverscript	In-Network			Out-of-Network
	Acute Drugs	Maintenance Drugs*	HEP Enrolled (Maintenance Drugs to treat chronic condition)	
Generic	\$5	\$5	\$0	20% of prescription cost
Preferred Brand	\$20	\$10	\$5	20% of prescription cost
Non-Preferred Brand	\$35	\$25	\$12.50	20% of prescription cost

To check which co-pay 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 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 <http://www.osc.ct.gov/empret/indxhlth.htm>) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

## When You Became Eligible for Medicare

If you are eligible for Medicare, you will be automatically enrolled in the SilverScript program. Your prescription benefits are the same but you use your SilverScript ID card for prescriptions instead.

When you are enrolled, you will receive more information. However, there are two key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- When you receive a letter from SilverScript giving you the chance to opt out or cancel your enrollment, don't do it. They are required to send you this letter but if you opt out, medical and prescription drug coverage for you and your dependents will terminate. You can just ignore it.
- If you receive a notice that you are required to pay a higher Medicare D premium, you must submit that notice to the Retirement Health Insurance Unit for reimbursement.
- If you receive your mail at a post office box, you must provide a street address to the Retirement Health Insurance Unit per Center for Medicare and Medicaid Services regulations.
- Do not enroll in an individual Medicare Part D prescription drug plan. Doing so would cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.

## 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 previous page, 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 or SilverScript at 1-866-693-4624.

## 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.

## Mandatory 90-Day Refills

Ninety-day refills are mandatory for maintenance medications. However, you do not have to use mail order. The initial 30-day supply can be filled at any participating pharmacy. After that, you can fill your medication at a pharmacy that participates in the state's Maintenance Drug Network, or use Caremark's mail order service. A link to the complete list of pharmacies in the Network can be found on the Office of the State Comptroller's website at [www.osc.ct.gov](http://www.osc.ct.gov).

## Health Enhancement Program (HEP)

When you and all of your enrolled family members participate in the HEP, you will pay lower monthly premiums and have no deductible for in-network care for the plan year.

### HEP Requirements and Benefits

When you enroll in the HEP, you and your enrolled family members will need to get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams). Those enrolled in the plan's dental program must also get dental cleanings. All of the plans cover up to two cleanings per year. Annual dental cleanings and unlimited periodontal care are included in HEP.

If you or any of your enrolled family members have **1)** Diabetes (Type 1 or 2), **2)** asthma or COPD, **3)** 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. Plus, you will be eligible to receive a \$100 cash payment, providing you and all enrolled family members comply with HEP requirements.

Before you enroll in HEP, you should review the requirements. The requirements are posted at [www.osc.ct.gov](http://www.osc.ct.gov).

### Enrolling in the HEP

Enrollment forms are available from the Retirement Health Insurance Unit at [www.osc.ct.gov](http://www.osc.ct.gov) or by calling (860) 702-3533. You do not have to enroll each year. If you are already enrolled, your participation will continue unless you disenroll during open enrollment or are deemed non-compliant.

If you do not participate in the 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. You will have the opportunity to choose whether or not to participate in HEP each year during open enrollment – you cannot change your mind mid-year.

### Health Enhancement Program (continued)

**If you do not report all requested information by May 31, 2012 you will be subject to higher monthly premiums and annual deductibles beginning July 1, 2012.**

### If You Are Already Enrolled in HEP

During this year's open enrollment, Health Enhancement Program (HEP) participants who have not completed the requirements must report the status of missing screenings or exams.

- Watch your home mailbox for a letter from your medical insurance carrier.
- If you are deemed compliant, you will receive a letter confirming your continued participation in HEP.
- If you are deemed non-compliant, you will receive a letter listing any missing requirements.
- If you haven't received a letter from your medical carrier about your HEP compliance, call the number on the back of your ID card.
- As long as you report the status of the requirements by May 31, 2012, you will be granted an extension through December 31, 2012 to fulfill your requirements.
- Reporting may be done using the State of Connecticut's secure HEP website, [www.cthep.com](http://www.cthep.com), or by paper form. If you need a paper form you may request one from the Retirement Health Insurance Unit or obtain one at [www.osc.ct.gov](http://www.osc.ct.gov).

## 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% (network only)	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**

\* 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, 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 37.)

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

# Your 2012-2013 Premium Share

## Monthly Medical Premiums July 1, 2012 through June 30, 2013

Medical plan options with no retiree premium share:

**Point of Enrollment - Gatekeeper Plans**

Anthem State BlueCare POE Plus  
UnitedHealthcare Oxford HMO

**Point of Enrollment Plans**

Anthem State BlueCare POE  
UnitedHealthcare Oxford HMO Select

**Out-of-Area Plans**

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, 2012 through June 30, 2013

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	\$28.91	\$26.59	\$27.86
2 Persons	\$57.82	\$53.18	\$61.30
3 or More Persons	\$57.82	\$53.18	\$75.23

### Important Note: Higher Premiums Without HEP

If your retirement date is October 2, 2011 or later you are eligible for the Health Enhancement Program (HEP). If you choose not to enroll, or enroll but do not meet the HEP requirements, your monthly premium share will be \$100 higher than shown above.

If you would like to change your HEP enrollment status, you may complete a form. Forms are available at [www.osc.ct.gov](http://www.osc.ct.gov) or from the Retirement Health Insurance Unit at (860) 702-3533.

### If You Retired Early

If you retired early, you may pay additional retiree premium share costs per the 2011 SEBAC agreement. For additional information, please contact the Retirement Health Insurance Unit at (860) 702-3533.



## 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 4-6, 8-10, 12-15 or 17-20, 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 4-6, 8-10, 12-15 or 17-20, as applicable). However, your premium share varies quite a bit (see pages 7, 11, 16 or 21, as applicable).
- 3. Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 23 and 24.)
- 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 25 – 29).

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 health care 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 health care 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 co-pays 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 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.

## 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 pages 4-6, 8-10, 12-15 or 17-20, 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 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 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 37 for phone numbers and websites.)

## 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

## 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](http://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.

<sup>1</sup> Anthem Health and Wellness Program Satisfaction Study.

*SpecialOffers@Anthem is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers@Anthem vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers@Anthem program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, [anthem.com](http://anthem.com). These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.*

\* Weight Watchers International, Inc., an independent company and owner of the WEIGHT WATCHERS trademark. All rights reserved. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association.

\* ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

## 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/stateact](http://anthem.com/stateact):

- **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<sup>SM</sup>

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/stateact](http://anthem.com/stateact).

### 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](http://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](http://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 37.

## ***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 37. 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.

# 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<sup>†</sup>
- 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](http://www.myuhcdental.com/statect)**.

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

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)

### 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.<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 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.

### 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](http://www.cigna.com)** or call us for LIVE assistance 24/7 at **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.*

## 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.<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](http://myCIGNA.com) for details.

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<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](http://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.**



# Retirement Health Insurance Open Enrollment Application



State Of Connecticut  
Office of the State Comptroller  
Healthcare Policy & Benefit Services Division  
Retirement Health Insurance Unit  
55 Elm Street  
Hartford, CT 06106-1775  
www.osc.ct.gov

**TYPE OR PRINT AND FORWARD TO THE RETIREMENT SERVICES DIVISION  
INSURANCE IS EFFECTIVE THE FIRST OF THE MONTH FOLLOWING THE RETIREMENT DATE**

RETIREE NAME (Person Receiving Benefit) (Last Name, First Name, MI)		RETIREMENT DATE	EMPLOYEE NUMBER (From Active Employment)
MAILING ADDRESS		TELEPHONE NUMBER	

## YOUR OPTIONS

This statement lists your benefit options. Use this page to select your medical and dental coverage. Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records. Please be aware that you and any dependents who enroll in medical coverage must also enroll in prescription coverage and that prescription coverage is not available to individuals who are not enrolled in a medical plan. Check the box to the left of the plan you wish to select.

### MEDICAL

#### ANTHEM

- State BlueCare POS
- State BlueCare POE
- State BlueCare POE Plus POE-G
- State Preferred POS – Currently Enrolled Only
- Out of Area Plan – Only if Retiree's Permanent Residence is Outside of Connecticut

#### OXFORD

- Oxford Freedom Select POS
- Oxford HMO Select POE
- Oxford HMO POE-G
- Oxford USA - Out of Area Plan – Only if Retiree's Permanent Residence is Outside of Connecticut

### DENTAL

- CIGNA Dental DHMO
- United Basic Dental
- United Enhanced Dental PPO

## RETIREE/DEPENDENTS

List you and all of your dependents to be enrolled in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

NAME	RELATIONSHIP (i.e., Spouse, Son, Daughter)	GENDER		DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAL & PRESCRIPTION	DENTAL
		F	M				
	<i>Retiree</i>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 1:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 2:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 3:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

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

When you are covered by the Health Plan Selected will you or your dependent(s) have any other coverage?  Yes  No  
If yes, which family member(s) will be covered by that insurance? (Check off as many that apply)

Self  Spouse  Children (List Names):

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

Is any member listed above eligible for Medicare?  Yes  No

If yes give Medicare Part A (Hospital Insurance) and Medicare B (Medical Insurance) effective date(s):

RETIREE		Dependent 1		Dependent 2		Dependent 3	
PART A (MO/YR)	PART B (MO/YR)						

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s). I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE
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Forms must be postmarked by May 31, 2012.

To enroll or make changes, clip out this form,  
complete it and return it to:

**Office of the State Comptroller  
Retirement Health Insurance Unit  
55 Elm Street  
Hartford, CT 06106-1775**

# Your Benefit Resources

For details about specific plan benefits and network providers, contact:

<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><a href="http://www.Anthem.com/statedct">www.Anthem.com/statedct</a></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><a href="http://www.OXHP.com/stateofct">www.OXHP.com/stateofct</a></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, non-Medicare eligible)</p>	<p><a href="http://www.Caremark.com">www.Caremark.com</a></p>	<p><b>1-800-318-2572</b></p>	
<p><b>SilverScript</b> (Prescription drug benefits, any medical plan, Medicare eligible)</p>	<p><a href="http://stateofconnecticut.silverscript.com">http://stateofconnecticut.silverscript.com</a></p>	<p><b>1-866-693-4624</b></p>	
<p><b>UnitedHealthcare (Dental)</b></p> <ul style="list-style-type: none"> <li>• Basic Plan</li> <li>• Enhanced PPO</li> </ul>	<p><a href="http://www.Myuhcdental.com/statedct">www.Myuhcdental.com/statedct</a></p>	<p><b>1-800-896-4834</b></p>	
<p><b>SIGNA</b></p> <ul style="list-style-type: none"> <li>• DHMO Plan</li> </ul>	<p><a href="http://www.Cigna.com">www.Cigna.com</a></p>	<p><b>1-800-244-6224</b></p>	

For information about eligibility, enrolling in the plans, making changes to your coverage, or premium share amounts, contact:

<p><b>Office of the State Comptroller Retirement Health Insurance Unit</b> 55 Elm Street Hartford, CT 06106-1775</p>	<p><a href="http://www.osc.ct.gov">www.osc.ct.gov</a></p>	<p><b>(860) 702-3533</b></p>	
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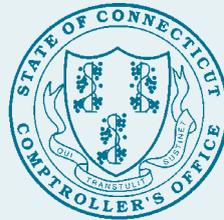




Healthcare Policy & Benefit Services Division  
 Office of the State Comptroller  
 55 Elm Street  
 Hartford, CT 06106-1775

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For State of Connecticut



# Retirees

HEALTH CARE OPTIONS PLANNER

2012-2013

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**Important information about dependent eligibility enclosed. See page 3.**

