State of Connecticut

2014
2015

Health Care Options Planner

Retirees

Retirement Date October 2, 2011 or Later

Table of Contents

Check Your HEP Status at www.cthep.com!

On the HEP website, you can check which HEP requirements you still have to complete, including for spouses and dependents. Go to www.cthep.com.

A Message from State Comptroller Kevin Lembo 2

What You Need to Do 3
- Current Retirees 3
- New Retirees 3
- Make Sure You Cover Only Eligible Dependents 4
- Qualifying Status Change 4

Health Enhancement Program (HEP) 5

Medical Plan Summaries 7

Prescription Drug Coverage 8

Medical Plan Premium Shares 11

Making Your Decision – Medical 12
- Comparing Networks 13
- Comparing Plan Features 15
- A Message From Anthem 16
- A Message From UnitedHealthcare 18
- Frequently Asked Questions 20

Dental Plan Summaries and Premium Shares 21
- A Message From CIGNA 23

Enrollment Form 25

Medicare and You 27

Your Benefit Resources 28

A Message from State Comptroller Kevin Lembo

Our daily choices affect our health and what we pay out of pocket for our health care. Even if you're happy with your current coverage, it's a good idea to review the plan options 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.

The State is pleased to announce that Cigna will now administer all three State dental plans at lower cost. This change will not alter your benefits – with the exception of some improvements – and you can continue to see your dentist under the larger network with no additional cost. The only change is that all three plans will simply be *administered* by Cigna.

During this open enrollment, if you have not previously enrolled in the Health Enhancement Program (HEP), you must decide if you want to participate in HEP for 2014-2015. HEP is designed to help you and your family work with your medical providers to make the best decisions about your health.

Those who participated in HEP during 2013-2014 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again and will continue to pay lower premiums for their health care coverage. Retirees eligible to participate in HEP must have retired on or after October 2, 2011.

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 care.

Kevin Lembo
State Comptroller

What's New for 2014-2015

Effective July 1, 2014, Cigna will be the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and DHMO. This change will bring lower premiums and a broader network of contracted dentists for the Basic and Enhanced plans. See page 21 for details.

2014-2015 medical premium shares are listed on page 11; dental premium shares are on page 22.

What You Need to Do

Current Retirees

Open Enrollment Through June 13, 2014

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 2014-2015. The form must be postmarked by June 13, 2014. Any changes you make are effective July 1, 2014 through June 30, 2015 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 11 for medical and page 22 for dental.**

Return completed enrollment forms to:

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

or
Fax: 860-702-3556

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.

What to Do When You Become Eligible for Medicare

See Medicare and You on page 27 for important information about what to do when becoming eligible for Medicare.

This planner provides a brief summary of covered services. See Your Benefit Resources on page 28 to receive more detailed information.

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 residing with you for whom you are the legal guardian may be eligible for coverage up to age 18 unless proof of continued dependency is provided. Disabled children may be covered beyond age 26 for medical or age 19 for dental. For your disabled child to remain an eligible dependent, they must be certified as disabled by your **medical** insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.

Once a judgment of divorce or legal separation is entered, your former spouse must be removed from the plan.

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

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

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).

Health Enhancement Program

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

HEP encourages retirees and enrolled family members to take charge of their health and health care by following health guidelines defined by getting age-appropriate wellness exams and preventive screenings.

You Save Money by Participating!

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

If You Do Not Enroll in HEP

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

How to Enroll in HEP

Current Retirees:

For those who are not currently participating in HEP, you can enroll during open enrollment. Forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533.

Those who participated in HEP during 2013-2014 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2014-2015 and will continue to pay lower premiums for their health care coverage.

New Retirees:

If you are a new retiree, you do not have to make a new HEP election – your HEP enrollment status will follow you into retirement. If you're not currently enrolled in HEP, you must complete the HEP enrollment form upon making your benefit elections. HEP enrollment forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533. If you do not wish to continue participation in HEP, you can disenroll during open enrollment.

2014 HEP PREVENTIVE CARE REQUIREMENTS

Preventive Service	Birth – age 5	Age 6 - 17	Age 18 – 24	Age 25 – 29	Age 30 – 39	Age 40 – 49	Age 50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50 - 64 – Every 3 years 65 and Over – Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 3 years	Every 2 years	Every year
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35 - 39**	As recommended by Physician	As recommended by Physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT

* Dental cleanings are required for family members who are participating in one of the State dental plans

** Or as recommended by your physician

As is currently the case under your State Health plan, any medical decisions will continue to be made by you and your physician

Health Enhancement Program Requirements

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

For calendar year 2014 you must complete at least one dental cleaning. All of the plans cover up to two cleanings per year. Periodontal maintenance is not subject to an annual maximum for HEP participants; however, cost shares and frequency limits may still apply. See page 21 for additional information.

Additional Requirements for Those With Certain Conditions

If you or any of your enrolled family members have **1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure),** you and/or that family member will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy co-pays for treatments related to your condition (see Your Prescription Drug Coverage at a Glance on page 8 for cost details).

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

Administrator and Website Visit www.cthep.com

Care Management Solutions, an affiliate of ConnectiCare, is the administrator for the Health Enhancement Program (HEP). The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. You can visit www.cthep.com to:

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals

You can also call Care Management Solutions to speak with a representative.

Care Management Solutions
www.cthep.com
(877) 687-1448
Monday – Thursday, 8:00 a.m. – 6:00 p.m.
Friday, 8:00 a.m. – 5:00 p.m.

To Create a New Account

All HEP enrollees, spouses, and dependents age 18 and over need to create a new online account the first time they visit www.cthep.com. An online tutorial provides information about the site and helps you with registering if you are a newcomer. Visit www.cthep.com and click on the hyperlink to your right.

Check Your Status

You have until December 31, 2014 to complete your 2014 HEP requirements. However, right now is a great time to check your status and schedule appointments for the requirements you need to complete this year.

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
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$15 co-pay		80%[1]
Preventive Care	No co-payment for preventive care visits and immunizations		80%[1]
Emergency Care	$35 co-pay[2]		$35 co-pay
Diagnostic X-Ray and Lab	100% (prior authorization required for diagnostic imaging)		80%[1] (prior authorization required for diagnostic imaging)
Pre-Admission Testing	100%		80%[1]
Inpatient Physician	100% (prior authorization required)		80%[1] (prior authorization required)
Inpatient Hospital	100% (prior authorization required)		80%[1] (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)		80%[1] (prior authorization required)
Ambulance	100% (if emergency)		100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%		80%,[1] up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	$15 co-pay, 1 exam per year[3]		50%, 1 exam per year
Audiological Screening	$15 co-pay, 1 exam per year		80%,[1] 1 exam per year
Mental Health/Substance Abuse	Prior authorization required		Prior authorization required
Inpatient	100%		80%[1]
Outpatient	$15 co-pay (prior authorization may be required)		80%[1] (prior authorization may be required)
Durable Medical Equipment	100% (prior authorization may be required)		80%[1] (prior authorization may be required)
Prosthetics	100% (prior authorization may be required)		80%[1] (prior authorization may be required)
Skilled Nursing Facility	100% (prior authorization required)		80%,[1] up to 60 days/year (prior authorization required)
Home Health Care	100% (prior authorization may be required)		80%,[1] up to 200 visits/year (prior authorization may be required)
Hospice	100% (prior authorization required)		80%,[1] up to 60 days (prior authorization required)
Annual Deductible	Individual: $350[4] Family: $350 each member[4] ($1,400 maximum)		Individual: $300 Family: $900
Annual Out-of-Pocket Maximums	Individual: $350[4] Family: $350 each member[4] ($1,400 maximum)		Individual: $2,000 (plus deductible) Family: $4,000 (plus deductible)
Lifetime Maximum	None		None
Pre-admission Authorization/ Concurrent Review	Through participating provider		Penalty of 20% up to $500 for no authorization

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

[2] Waived if admitted.

[3] HEP participants have $15 co-pay waived once every two years.

[4] Waived for HEP-compliant members.

Your Prescription Drug Coverage at a Glance

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. 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. See page 27 for more details.

If you are NOT Medicare eligible, your prescription benefits are 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 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

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

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

When You Become 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.

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.

See Medicare and You on page 27 for more details.

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 request a brand-name drug over a generic alternative without obtaining a coverage exception, 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.

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!** In order to receive the $0 copay, your maintenance prescriptions must be filled in one of two ways:

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

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

Non-Medicare Retirees Mandatory 90-Day Refills

If you are not enrolled in Medicare, 90-day refills are mandatory for maintenance medications. 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.

Your 2014-2015 Medical Premium Share

Monthly Medical Premiums July 1, 2014 through June 30, 2015

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	ANTHEM PREFERRED Closed to New Enrollment
1 Person on Medicare	$0.00	$0.00	$0.00
1 Person not on Medicare	$12.61	$13.00	$12.82
1 Person not on Medicare and 1 on Medicare	$12.61	$13.00	$12.82
1 not on Medicare and 2 on Medicare	$12.61	$13.00	$12.82
2 on Medicare	$0.00	$0.00	$0.00
2 not on Medicare	$27.74	$28.60	$28.21
2 not on Medicare and 1 on Medicare	$27.74	$28.60	$28.21
3 or more on Medicare	$0.00	$0.00	$0.00
3 or more not on Medicare	$34.04	$35.10	$34.62
3 or more not on Medicare and 1 on Medicare	$34.04	$35.10	$34.62

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 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 – Medical

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your 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 benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 7).
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 page 7). However, your premium share varies quite a bit depending on the carrier and plan selected (see page 11).
3. **Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 13 and 14).
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 13 – 20).

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:

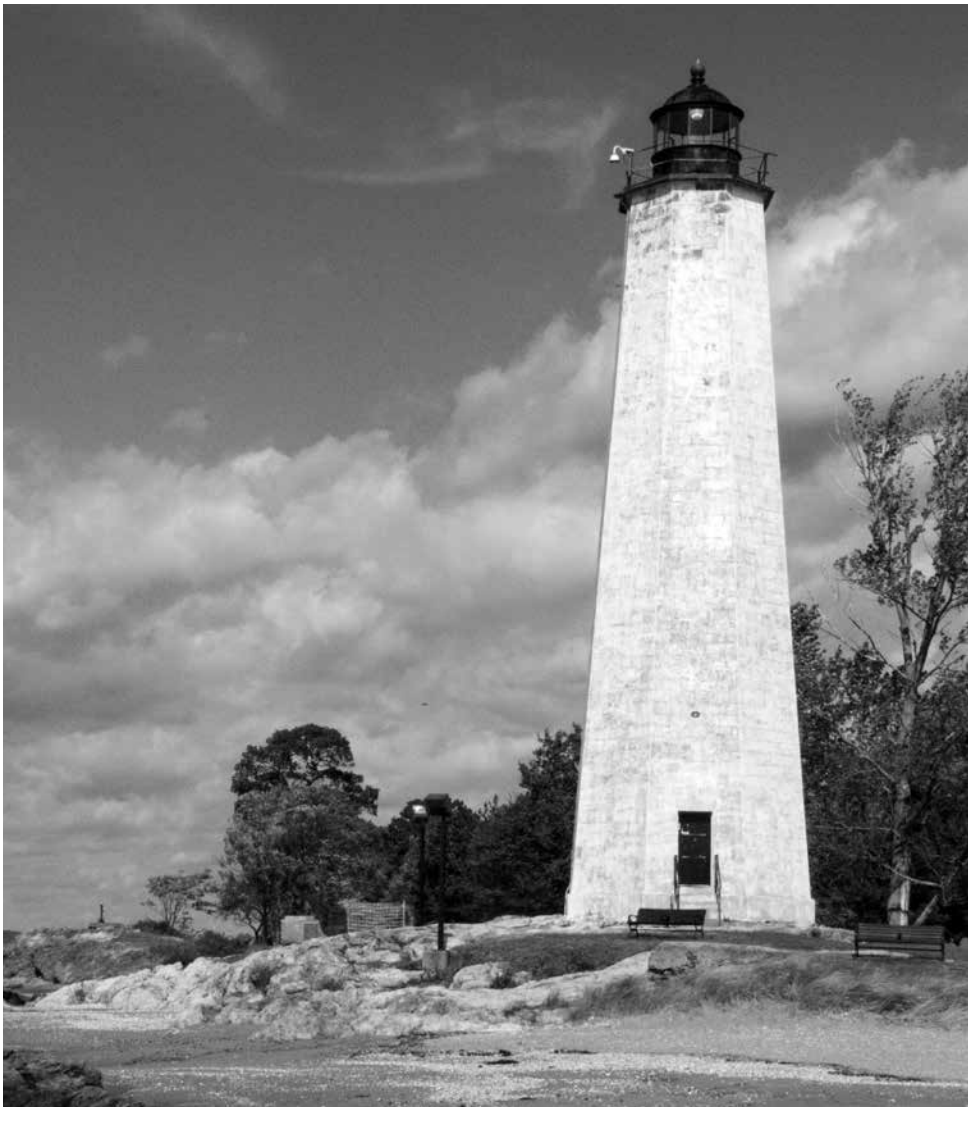
- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care –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

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. Take a look at your options before you decide.



How the Plans Work

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

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

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

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 28).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 28).

Using Out-of-Network Providers

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

In the POS plans there are no referral or prior authorization requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require prior authorization (see page 7), 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 geographic area covered by Oxford's 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 28 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 new enrollment.

A Healthy You Starts Here

Get on the road to good health with our large network of doctors, easy-to-use wellness tools and programs, and top-notch customer service.

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.

Exceptional Customer Service

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

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

24/7 NurseLine

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

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

Easy-to-Use Wellness Tools and Programs

Lose weight. Join a gym. Reduce stress. 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.

Anthem's Health and Wellness programs

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 Anthem Health and Wellness programs. Here's a sampling of what's available to you by accessing the State dedicated website at anthem.com/statect:

- **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 Anthem Health and Wellness programs.

SpecialOffers@Anthem

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

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

Get the Most From Your Health Plan

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 offers things like vision discounts 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.

- **1-800 CONTACTS** — Get contact lenses quick and easy — plus discounts like $20 off when you spend $100 or more, and free shipping.
- **Glasses.com** — Try on any five of the 1,500 designer frames — at home, for free — before you buy. It's convenient, plus you get savings like $20 off when you spend $100 or more, and free shipping and free returns.
- **Premier LASIK** — Save 15% on LASIK with all their in-network providers and prices as low as $695 per eye with select providers.

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.

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

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. 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.

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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.

Now is the Time to Live Well.

Top Reasons UnitedHealthcare is the right decision for you and your family:

Trust

You should trust that you are making a great decision choosing UnitedHealthcare. You need to choose someone you can depend on and with an Oxford Health Plan from United-Healthcare you come first. We are committed to helping people live healthier lives.

We Care

UnitedHealthcare Children's Foundation (UHCCF) is a non-profit charity dedicated to enhancing the quality of children's lives. UHCCF was founded in 1999. Since 2007, UHCCF has awarded more than 6,500 grants valued at over $20M to children and their families across the United States.

Tools and Resources

Everything you need at your fingertips, 24/7. Search for a doctor, view your claims, online health coaching and much more.

Our Network

All medical plans offer access to our local and national network

UnitedHealthcare offers a robust local and national network. Nationally, and in the tri-state area, we have a vast number of physicians, healthcare professionals and hospitals. For years, our members have relied on access to our Connecticut, New York and New Jersey tri-state network. Whichever plan you choose, you'll also have seamless access to our UnitedHealthcare Choice Plus Network of physicians and healthcare professionals outside of the tri-state area. This gives State of Connecticut employees and retirees better access to quality care whether you are in Connecticut, traveling outside the tri-state area or living somewhere else in the country.

For more information about our network, or to search for physicians participating in our local or UnitedHealthcare Choice Plus national Network, please visit welcometouhc.com/stateofct.

UnitedHealth Premium® Program
UnitedHealthcare has long recognized the direct relationship between health care quality and successful outcomes.

The Premium program recognizes doctors who meet standards for quality and cost efficiency. The quality standards are based on evidence-based medicine and national industry guidelines. The cost efficiency standards are based on local market benchmarks for cost-efficient care.

Premium Designation Display

Doctors who have met the criteria for quality and/or cost efficiency could have one of these four UnitedHealth Premium designations. These are shown when searching for a provider online, and in provider directories:

- Quality & Cost Efficiency
- Cost Efficiency & Not Enough Data to Assess Quality
- Quality & Not Enough Data to Assess Cost
- Quality & Did Not Meet Cost Efficiency

Physician designations are subject to change. Members should always visit welcometouhc.com/stateofct and check their doctor's Premium designation before making an appointment.

Introducing UnitedHealth Premium Tier 1

UnitedHealth Premium Tier 1 helps people to quickly and easily find doctors who have been recognized for providing value.

UnitedHealth Premium Tier 1 physicians have received the Premium designation for:

- Quality & Cost Efficiency OR
- Cost Efficiency & Not Enough Data to Assess Quality

For more information about the Premium program, visit welcometouhc.com/stateofct

The choice is yours.

The UnitedHealth Premium program can help you find the care you want. The program evaluates doctors in 25 different medical specialties, using national standards for quality and local benchmarks for cost efficiency. You can use this information to help you choose the care that's right for you.

Oxford On-Call®

Healthcare Guidance 24 hours a day

We realize that questions about your health can come up at any time. That's why we offer you flexible choices in health care guidance through our *Oxford On-Call®* program. Speak with a registered nurse who can offer suggestions and guide you to the most appropriate source of care, 24 hours a day, seven days a week. That's the idea behind *Oxford On-Call.*

If you are a member and you need to reach Oxford-On-Call, please call 800-201-4911. Press option 4. Oxford On-Call can give you helpful information about many topics such as:

General Health Information
Call about illness, injury, chronic conditions, prevention, healthy living, and men's, women's and children's health.

Deciding Where to Go for Care
Oxford On-Call's nurses provide information that can help you choose care that is appropriate for your situation.

Choosing Self-Care Measures
Registered nurses provide practical self-care tips to help you manage your condition at home.

Guidance for Difficult Decisions
If you or a family member has a serious medical condition, *Oxford On-Call* nurses can be a great resource. The more you know, the better prepared you'll be.

Live Web Chat

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

For additional information regarding *Oxford On-Call,* please visit welcometouhc.com/stateofct.

Healthy Bonus® Member Discounts

We understand that rising health care costs nationwide affect our members. We strive to help you stretch your health care dollar by developing programs that aim to help you improve your health.

We recognize there are ways we can help members reduce out-of-pocket health care costs. We believe in the power of prevention: that by taking a little extra time to eat better, exercise and reduce stress, individuals can do a better job of staying on the path of wellness.

Our *Healthy Bonus* program offers access to discounts and special offers on products and services that can help you make the best kind of investment: a healthy lifestyle. Please visit welcometouhc.com/stateofct to obtain information on the discounts offered to you on things like fitness/fitness equipment, diabetes/disease management, keeping kids healthy and overall wellness.

UnitedHealth Allies

This health discount program helps you, and your family, save money on many health and wellness purchases not included in your standard health benefit plan. To begin enjoying these discounts, go to **unitedhealthallies.com** and sign up. You will need your Oxford ID number and UnitedHealth Allies card. If you do not have your UnitedHealth Allies card, call Customer Care at **800-860-8773.**

Frequently Asked Questions

1. 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 28.

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

If you live permanently outside of Connecticut, we will automatically place you in an Out of Area plan, giving you access to a national network of providers whether you are enrolled with Anthem or UnitedHealthcare Oxford. There are no retiree premium shares for enrollment in an Out-of-Area plan.

3. 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.

4. 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.

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

6. 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 4). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

7. 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. It is also important to note that you may not double cover yourself under another State of Connecticut retiree's health benefits.

Your Dental Plans at a Glance

State of Connecticut Dental Plans Administered By Cigna

Effective July 1, 2014, Cigna will be the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and Dental HMO (DHMO). If you are currently in the Basic or Enhanced plan, here's what this means to you:

- Under the Basic and Enhanced plans, the State was able to modernize and improve some benefits. For example, under the Basic plan, sealants will now be covered for children up to age 16 (the applicable cost share will apply). Under the Enhanced plan, there will now be coverage for implants, up to $500 per year. In addition, under both the Basic and Enhanced plans you will receive discounted rates for non-covered services when utilizing a network dental provider (unless this is prohibited by state law – see page 22 for details).
- How you utilize the networks will not change. Under the Basic plan you can continue to see any dentist with no additional charge. Under the Enhanced plan you will have lower costs if you use a Cigna Dental PPO network provider.
- You still have the option to choose the Basic plan, Enhanced plan, or Dental HMO plan. **If you decide NOT to make a dental plan change during Open Enrollment, your coverage will automatically default to the same plan type administered by Cigna.**

If you are enrolled in the Basic or Enhanced plan, you will receive a new ID card from Cigna.

	BASIC PLAN (any dentist)	**ENHANCED PLAN** (network)	**DHMO® PLAN** (network only)
Annual Deductible	None	$25 individual, $75/family	None
Annual Maximum	None ($500 per person for periodontics)	$3,000 per person (excluding orthodontics)	None
Exams, Cleanings, and X-rays	Covered at 100%	Covered at 100%[1]	Covered at 100%
Periodontal Maintenance	Covered at 80%[2]	Covered at 100%[2]	Covered[3]
Simple Restoration			
Fillings	Covered at 80%	Covered at 80%	Covered[3]
Oral Surgery	Covered at 67%	Covered at 80%	Covered[3]
Major Restoration			
Crowns	Covered at 67%	Covered at 67%	Covered[3]
Dentures, Fixed Bridges	Not covered[4]	Covered at 50%	Covered[3]
Implants	Not covered[4]	Covered at 50% (up to $500)	Not covered
Orthodontia	Not covered	Plan pays $1,500 per person per lifetime	Covered[3]

1 In the Enhanced plan, be sure to use an in-network dentist to ensure receiving 100% coverage; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.

2 If enrolled in the Health Enhancement Program: No annual maximum on services for periodontal maintenance (2 per calendar year) or scaling and root planing (frequency limits and cost shares may still apply).

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

4 While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 22 for details).

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 Cigna at 1-800-244-6224 or www.Cigna.com/stateofct.

Terms to Know

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

Enhanced Plan – 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.

Your 2014-2015 Dental Premium Share

Dental Premiums July 1, 2014 through June 30, 2015

COVERAGE LEVEL	Basic Plan	Enhanced Plan	DHMO Plan
1 Person	$28.93	$22.89	$28.46
2 Persons	$57.87	$45.78	$62.60
3 or More Persons	$57.87	$45.78	$76.83

Savings on Non-Covered Services

Many of the Basic and Enhanced plan Cigna PPO network dentists have agreed to offer their discounted fees to you and your covered dependents for non-covered services. These savings may also apply to services that would not be covered because you reached your annual benefit maximum or due to other plan limitations such as frequency, age, or missing tooth limitations.

- You can get savings on most services not covered under the dental PPO plans
- You must visit network dentists to receive the Cigna dental PPO discounts (savings will not apply with non-participating dentists)
- You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment
- You are responsible for paying the negotiated fees directly to the dentist.

* *Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Be sure to check with your dental care professional or contact Cigna customer service before receiving care to determine if these discounts will apply to you.*

Frequently Asked Questions

1. How do I know which dental plan is best for me?

This is a question only you can answer. Each plan offers different advantages. To help choose which plan might be best for you, compare the plan-to-plan features in the chart on page 21 and weigh your priorities.

2. How long can my children stay on the dental plan? Can they stay covered until their 26th birthday like with the medical plans?

The Affordable Care Act extended benefits for children until age 26 only under medical and prescription drug coverage, not dental. Dental coverage ends for dependent children at age 19 (unless they are disabled*).

* *For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

3. Do any of the dental plans cover orthodontia for adults?

Yes, the Enhanced Plan and DHMO both cover orthodontia for adults up to certain limits. The Enhanced Plan pays $1,500 per person (adult or child) per lifetime. The DHMO requires a copay. The Basic Plan does not cover orthodontia for adults or children.

4. If I participate in HEP, are my regular dental cleanings 100% covered?

Yes, up to two per year. However, if you are in the Enhanced plan, you must use an in-network dentist to get the full coverage. If you go out of network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge). And of course in the DHMO, you must use a network dentist or your exam won't be covered at all.

A Message From Cigna

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.

Cigna will now be the dental carrier for all State of Connecticut dental plans. As a State of Connecticut employee, you and your family have the opportunity to receive quality dental care through one of the following plans:

- **Basic Plan**
- **Enhanced Plan**
- **DHMO Plan**

Terms to Know

Basic Plan

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

Enhanced Plan

This plan offers dental services both within and outside of a 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.

If you visit a dentist who is not part of the Cigna PPO Network, he or she is considered out-of network. The Enhanced Plan pays for covered dental services based on "MAC" or "Maximum Allowable Charge." The MAC is the amount your plan would pay had you visited an in-network dentist. When you visit an out-of-network dentist, you are responsible for any and all charges above the MAC; up to that dentist's usual charge for those services.

DHMO Plan

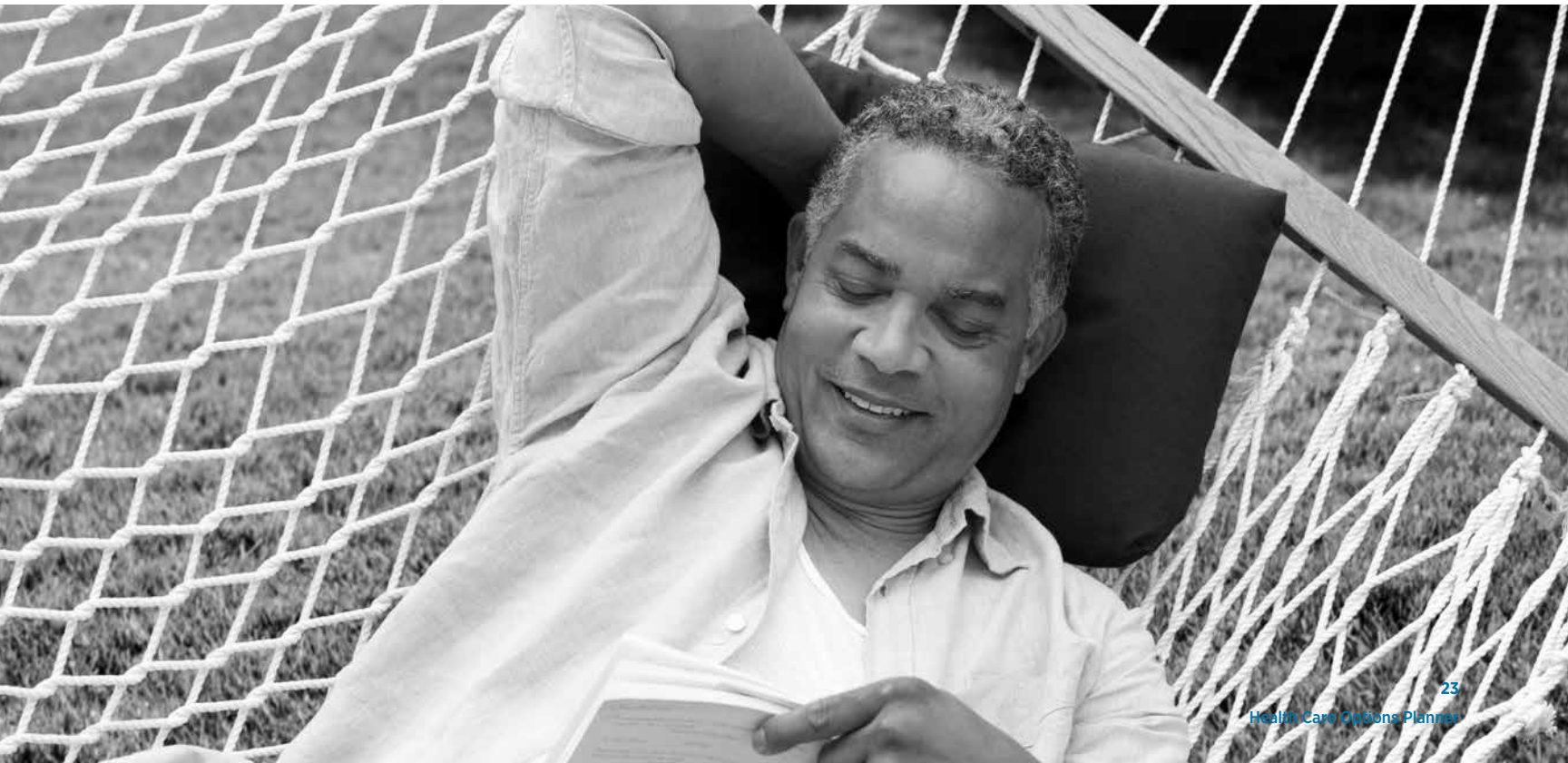
This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

Pre-Enrollment Information Line & Finding a Dentist

You can speak to a knowledgeable Cigna enrollment specialist 24 hours a day, 7 days a week by calling **1.800.564.7642.**

For the most current information on network dental offices in your area, search the online directory at **www.cigna.com/stateofct** or call the Dental Office Locator at **1.800.564.7642.**

Access personalized benefit information at myCigna.com. After you enroll for coverage, you can register for an account.



What's New

- All dental plans administered by Cigna
- 24/7 Customer Support
- Claims handled by Cigna
- Increased network of contracted dentists
- New ID Cards
- Implants covered under the Enhanced plan (up to $500/year)

Access your dental benefit information by going to www.cigna.com/stateofct.

Oral Health Integration Program

Eligible State of Connecticut members who enroll in dental coverage will have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program® (OHIP). With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services. Please visit **www.cigna.com/stateofct** for more information.

Healthy Rewards®

Cigna's Healthy Rewards Program provides discounts of up to 60% on healthy programs and services as part of Cigna's ongoing effort to promote wellness. There's no time limit or maximum to enjoy these instant savings when you visit a participating provider or shop online. No referrals or claim forms needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins.

After you enroll in the insurance plan, you can learn more about Healthy Rewards by visiting **www.Cigna.com/rewards** (password: savings) or calling **1.800.258.3312.**

Orthodontics in Progress

If you choose the Enhanced plan which covers orthodontic care, you will have coverage for treatment in progress. The coverage will begin at the effective date of your Cigna plan. Any services incurred prior to the effective date would be paid by your previous carrier.

Your benefit amount is determined by your plan's benefit level for orthodontia and the number of months of active treatment remaining when the Enhanced plan with Cigna takes effect. For additional information, please visit **www.cigna.com/stateofct.**

Dental Treatment in Progress

Some dental procedures require several treatment dates from start to finish. For example, a root canal generally requires two visits – one for the core build-up and a second for crown placement. As a general rule, claims for a "treatment in progress" are paid by the insurance carrier you were enrolled with when the treatment began.

For example, a crown procedure that starts in June 2014 under the previous plan but is completed in July 2014 after the Cigna plan becomes effective is considered treatment in progress and is paid under the previous plan.

Other examples might include treatment for a root canal, crown and bridge, or dentures. If your treatment began before July 1, 2014, your provider should submit the claim directly to the previous plan for review. This is a standard process in the insurance industry for transition of care.

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**

☐ Waive/Cancel Medical and Prescription Coverage

DENTAL

☐ Basic Dental Plan ☐ Enhanced Dental Plan ☐ Dental HMO Plan ☐ Waive/Cancel Dental Coverage

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 F	GENDER M	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAL & PRESCRIPTION	DENTAL
	Retiree	☐	☐			☐	☐
	Dependent 1:	☐	☐			☐	☐
	Dependent 2:	☐	☐			☐	☐
	Dependent 3:	☐	☐			☐	☐

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)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	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

Forms must be postmarked by June 13, 2014.

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

or
Fax: 860-702-3556

Medicare and You

Medicare is a federal healthcare insurance program for people age 65 and older. While the Social Security retirement age is creeping up, the eligibility age to start Medicare is age 65. People younger than age 65 may also qualify for Medicare due to certain disabilities or health conditions (such as permanent kidney failure or Lou Gehrig's disease). If you or a dependent becomes eligible for Medicare due to disability no matter what age, be sure to contact the Retirement Health Insurance Unit at 860-702-3533. This section covers Medicare for retirees only.

Medicare coverage is made up of various parts. If you are eligible for Medicare, you are automatically covered by Medicare Part A (hospital care) and must enroll yourself in Medicare Part B (physician services).

What to Do When You Become Eligible for Medicare

When you reach age 65, your State of Connecticut medical and prescription drug benefits will "wrap around" your Medicare benefits. Medicare will be your primary coverage and your State of Connecticut sponsored plan will pay after Medicare. This means you continue the same level of benefits that you are used to.

Do Enroll in Medicare Part A and B

Medicare Part A is free and enrollment automatic if you are at least age 65.You must enroll in Medicare Part B and pay a premium. It is essential that you enroll in Medicare Parts A and B for the first of the month you are first eligible for enrollment. Typically this is the first of the month in which you turn 65. Failing to do so will result in a "hole" in your coverage. Your State sponsored medical and prescription coverage will automatically be noted as secondary upon your 65th birthday.

Your standard premium for Medicare Part B 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.) The 2014 standard Medicare Part B/Part D premium reimbursement is $104.90, as long as you are not receiving reimbursement from any other source.

Be sure to send us a copy of your red, white and blue Medicare card as soon as you receive it. You will receive a letter from the Retirement Health Insurance Unit with more information just prior to your reaching age 65.

Additionally, you may be required to pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Parts B and D in addition to the standard rate. Social Security will advise you by letter annually if you are required to pay a higher rate. Send a copy of this letter along with your red, white, and blue Medicare card in order to receive full reimbursement.

Do Not Enroll in Medicare Part C or Part D

The State of Connecticut prescription coverage with SilverScript (a subsidiary of Caremark) is a Medicare Part D plan. When you or your covered dependents become eligible for Medicare, you will automatically be enrolled in the Part D prescription drug plan administered by SilverScript. You do not need to do anything except start using your SilverScript card once received.

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

- **Do not opt out of the SilverScript prescription drug program.** SilverScript is required by Medicare to send you a letter giving you a chance to opt out or cancel your prescription drug enrollment, **but don't do it.** If you opt out, medical and prescription drug coverage from for you and your dependents will terminate. **Please ignore the opt out letter.**
- **Do not enroll in an individual Medicare prescription drug plan (through Medicare Part C or Part D).** You are only able to enroll in one Medicare Part D plan. Your State sponsored coverage with SilverScript is a Medicare Part D plan enrollment. Enrolling in any other Medicare Part D plan will cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.
- **Do make sure we have your street address.** If you receive your mail at a post office box, you must provide a residential street address to the Retirement Health Insurance Unit (per Center for Medicare and Medicaid Services regulations). All communication will still go to your noted mailing address.
- **Do promptly submit higher premium notices.** If your premium will be more than the standard premium rate, send a copy of your 2014/2015 IRMAA notice to the Retirement Health Insurance Unit to ensure proper reimbursement.

If Family Members Are Not Yet Eligible for Medicare

If you have covered dependents who are not yet eligible for Medicare (typically those under age 65), their current coverage through CVS Caremark will stay the same. There will be no change to their co-pay structure, and they will continue to participate in the mandatory maintenance drug network program. This means that after their first fill of a maintenance medication, refills must be filled through a pharmacy participating in the State's Maintenance Drug Network or through the CVS Caremark mail-order pharmacy. A full list of all participating pharmacies is available on the Comptroller's website at **www.osc.ct.gov.**

For More Information

Contact SilverScript with questions about your prescription coverage, ID cards, and participating pharmacies or the Retirement Health Insurance Unit with questions about eligibility or premiums. Contact information is at the back of the booklet.

Have Questions for SilverScript?

Call 866-693-4624

Your Benefit Resources

For details about specific plan benefits and network providers, contact:			
Health Enhancement Program (HEP) Care Management Solutions (an affiliate of ConnectiCare)	**www.cthep.com**	**1-877-687-1448**	
Anthem Blue Cross and Blue Shield • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area • Anthem State BlueCare (POS)	**www.Anthem.com/statect**	**1-800-922-2232**	
UnitedHealthcare (Oxford) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford USA Out-of-Area	**www.welcometouhc.com/stateofct**	**1-800-385-9055** Call 1-800-760-4566 for questions before you enroll	
Caremark (Prescription drug benefits, any medical plan, non-Medicare eligible)	**www.Caremark.com**	**1-800-318-2572**	
SilverScript (Prescription drug benefits, any medical plan, Medicare eligible)	**http://stateofconnecticut.silverscript.com**	**1-866-693-4624**	
CIGNA • Basic Plan • Enhanced Plan • DHMO Plan	**www.Cigna.com/stateofct**	**1-800-244-6224**	
For information about eligibility, enrolling in the plans, making changes to your coverage, or premium share amounts, contact:			
Office of the State Comptroller Retirement Health Insurance Unit 55 Elm Street Hartford, CT 06106-1775	**www.osc.ct.gov**	**(860) 702-3533**	

Healthcare Policy & Benefit Services Division
Office of the State Comptroller
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New 2014-2015 premium shares.
See pages 11 and 22.