STATE OF CONNECTICUT

2017 | 2018

Retirement Date October 1, 2011 or Earlier

RETIREES HEALTH CARE OPTIONS PLANNER

A MESSAGE FROM

Kevin LEMBO

STATE COMPTROLLER

Our daily choices affect our health and what we pay out of pocket for 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.

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

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2017-2018 Premium Shares

2017-2018 medical premium shares are listed on pages 5, 9, and 13 (depending on your retirement date).

Dental premiums are listed on page 25.

For additional details, please go to the Comptroller's website at www.osc.ct.gov or check with the Retirement Health Insurance Unit at (860) 702-3533.

How to Use This Planner

This planner is for all State of Connecticut retirees who retired October 1, 2011 or earlier. 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 2017-2018 Medical Premium Share" pages are customized by group.

GROUP 1:
If your **retirement date is before July 1997,** see pages 5-7 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 12-15 for information that applies specifically to you.

What You Need to Do

Open Enrollment Through June 9, 2017

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 2017-2018. The form must be postmarked by June 9, 2017. Any changes you make are effective July 1, 2017 through June 30, 2018 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 5, 9 or 13 (as applicable).**

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

What to Do When You Become Eligible for Medicare

See Medicare and You on page 28 for important information about what to do when becoming eligible for Medicare.

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. 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.

This planner provides a brief summary of covered services. See Your Benefit Resources on page 31 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.
- **Loss of coverage** – Any event that causes you or your dependent to lose coverage from another source.

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 POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	BOTH CARRIERS POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$5 co-pay	80% [1]
Preventive Care	No copayment for preventive care visits and immunizations	80% [1]
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% [1]
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	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 [2]	$5 co-pay	80% [1]
Durable Medical Equipment [2]	100%	80% [1]
Hearing Aids	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period	80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
Prosthetics [2]	100%	80% [1]
Skilled Nursing Facility	100% (prior authorization required)	80%, [1] up to 60 days/year (prior authorization required)
Home Health Care [2]	100%	80%,[1] up to 200 visits/year
Hospice	100% (prior authorization required)	80%,[1] up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	$300
Family (3 or more)	None	$900
Annual Out-of-Pocket Maximums		
Each Individual	$2,000	$2,000 (plus deductible)
Family	$4,000	$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] Prior authorization may be required.

Visit www.osc.ct.gov for the Summary of Benefits and Coverage (SBC) for medical and pharmacy.

Your 2017-2018 Medical Premium Share

There are no monthly medical premium retiree shares for your medical and prescription benefits. See page 25 for dental premiums.

The State reimburses your Medicare Part B premiums beginning when the Retirement Health Insurance Unit receives your Medicare card. If you aren't receiving this benefit, contact us. See page 28 for information.

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.

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 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 and Maintenance Drugs	Caremark Mail Order/ Maintenance Drug Network*	
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 not required to fill your maintenance drug prescription using the maintenance drug network or CVS Mail Order. However, if you do, you will get a 90-day supply of maintenance medication for a $0 co-pay.

MEDICARE-ELIGIBLE

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

For information about SilverScript visit http://stateofconnecticut.silverscript.com or call 1-866-693-4624.

When You Become Eligible for Medicare

See Medicare and You on page 28 for more details.

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.

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.) 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. The Coverage Exception Request form is available at www.osc.ct.gov.

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 Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	BOTH CARRIERS POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$15 co-pay ($5 if retired before July 1, 1999)	80% [1]
Preventive Care	No copayment for preventive care visits and immunizations	80% [1]
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% [1]
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	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 [2]	$15 co-pay ($5 if retired before July 1, 1999)	80% [1]
Durable Medical Equipment [2]	100%	80% [1]
Hearing Aids	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period	80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
Prosthetics [2]	100%	80% [1]
Skilled Nursing Facility	100% (prior authorization required)	80%,[1] up to 60 days/year (prior authorization required)
Home Health Care [2]	100%	80%,[1] up to 200 visits/year
Hospice	100% (prior authorization required)	80%,[1] up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	$300
Family (3 or more)	None	$900
Annual Out-of-Pocket Maximums		
Each Individual	$2,000	$2,000 (plus deductible)
Family	$4,000	$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] Prior authorization may be required.

Visit www.osc.ct.gov for the Summary of Benefits and Coverage (SBC) for medical and pharmacy.

Your 2017-2018 Medical Premium Share

Monthly Medical Premiums July 1, 2017 through June 30, 2018

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 - 5/1/09	Non-ERIP Retirement Date 7/97 - 6/99	Retirement Date 7/1/99 - 5/1/09	Retirement Date 7/1/99 - 5/1/09
1 Person on Medicare	$0.00	$0.00	$0.00	$0.00
1 Person not on Medicare	$16.08	$0.00	$16.28	$16.60
1 Person not on Medicare and 1 on Medicare	$16.08	$0.00	$16.28	$16.60
1 not on Medicare and 2 on Medicare	$16.08	$0.00	$16.28	$16.60
2 on Medicare	$0.00	$0.00	$0.00	$0.00
2 not on Medicare	$35.37	$0.00	$35.81	$36.52
2 not on Medicare and 1 on Medicare	$35.37	$0.00	$35.81	$36.52
3 or more on Medicare	$0.00	$0.00	$0.00	$0.00
3 or more not on Medicare	$43.41	$0.00	$43.95	$44.82
3 or more not on Medicare and 1 on Medicare	$43.41	$0.00	$43.95	$44.82

See page 25 for dental premiums.

The State reimburses your Medicare Part B premiums beginning when the Retirement Health Insurance Unit receives your Medicare card. If you aren't receiving this benefit, contact us. See page 28 for information.

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 and Maintenance Drugs	Caremark Mail Order/ Maintenance Drug Network*	
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 not required to fill your maintenance drug prescription using the maintenance drug network or CVS Mail Order. However, if you do, you will get a 90-day supply of maintenance medication for a $0 co-pay.

MEDICARE-ELIGIBLE

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

For information about SilverScript visit http://stateofconnecticut.silverscript.com or call 1-866-693-4624.

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.

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

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!** Maintenance prescriptions can be filled in 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.

When You Become Eligible for Medicare

See Medicare and You on page 28 for more details.

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.) 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. The Coverage Exception Request form is available at www.osc.ct.gov.

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 Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	BOTH CARRIERS POS OUT-OF-NETWORK
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Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% [1]
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	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 [2]	$15 co-pay	80% [1]
Durable Medical Equipment [2]	100%	80% [1]
Hearing Aids	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period	80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
Prosthetics [2]	100%	80% [1]
Skilled Nursing Facility	100% (prior authorization required)	80%,[1] up to 60 days/year (prior authorization required)
Home Health Care [2]	100%	80%,[1] up to 200 visits/year
Hospice	100% (prior authorization required)	80%,[1] up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	$300
Family (3 or more)	None	$900
Annual Out-of-Pocket Maximums		
Each Individual	$2,000	$2,000 (plus deductible)
Family	$4,000	$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] Prior authorization may be required.

Visit www.osc.ct.gov for the Summary of Benefits and Coverage (SBC) for medical and pharmacy.

Your 2017-2018 Medical Premium Share

Monthly Medical Premiums July 1, 2017 through June 30, 2018

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 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	$16.08	$16.60	$16.28
1 Person not on Medicare and 1 on Medicare	$16.08	$16.60	$16.28
1 not on Medicare and 2 on Medicare	$16.08	$16.60	$16.28
2 on Medicare	$0.00	$0.00	$0.00
2 not on Medicare	$35.37	$36.52	$35.81
2 not on Medicare and 1 on Medicare	$35.37	$36.52	$35.81
3 or more on Medicare	$0.00	$0.00	$0.00
3 or more not on Medicare	$43.41	$44.82	$43.95
3 or more not on Medicare and 1 on Medicare	$43.41	$44.82	$43.95

See page 25 for dental premiums.

The State reimburses your Medicare Part B premiums beginning when the Retirement Health Insurance Unit receives your Medicare card. If you aren't receiving this benefit, contact us. See page 28 for information.

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 and Maintenance Drugs	Caremark Mail Order/ Maintenance Drug Network*	
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 not required to fill your maintenance drug prescription using the maintenance drug network or CVS Mail Order. However, if you do, you will get a 90-day supply of maintenance medication for a $0 co-pay.

MEDICARE-ELIGIBLE

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

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.

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

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.

For information about SilverScript visit http://stateofconnecticut.silverscript.com or call 1-866-693-4624.

When You Become Eligible for Medicare

See Medicare and You on page 28 for more details.

Preferred and Non-Preferred Brand-Name Drugs

A drug's tier placement is determined by Caremark's Pharmacy and Therapeutics Committee on a quartly basis. 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.

Your Prescription Drug Coverage at a Glance (continued)

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!** Maintenance prescriptions can be filled in 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.

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.

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 with the same co-pays. 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 31.

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.

Q&A

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

6. 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.

7. 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.

8. If I'm eligible, should I sign up for Medicare?

Yes. Please be sure to enroll in Medicare Part A and B as soon as you're eligible. Your standard premium for Medicare Part B will be reimbursed by the State beginning when the Retirement Health Insurance Unit receives your Medicare card. See page 28 for more information.

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 sidebar at left for pages specific to your retirement date.)
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.

   However, your premium share varies quite a bit depending on the carrier and plan selected. (see sidebar at left for pages specific to your retirement date).
3. **Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 19-20.)
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 19-23).

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

GROUP 1:
If your **retirement date is before July 1997,** see pages 5-7 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 12-15 for information that applies specifically to you.

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:

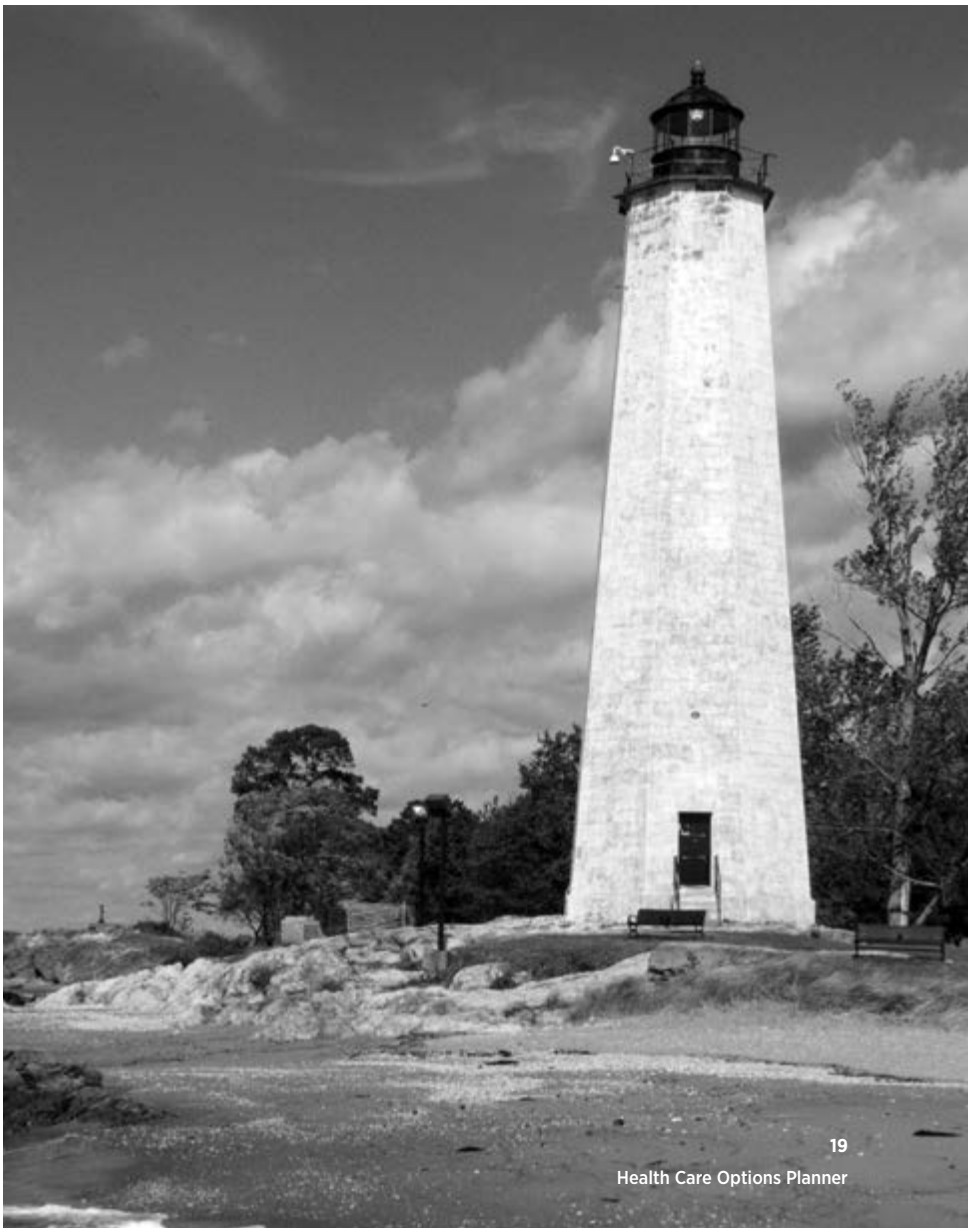
- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – 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 31).

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 31).

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. In most cases, 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 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 5, 8 and 12 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 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 31 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 Out of Area
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.

Good health starts with a plan

Check out our programs and services to help improve your health

Anthem BlueCross BlueShield

Customer service: get answers and much more

The State of Connecticut Enhanced Member Service Unit can answer your questions and give you information on your benefits and our wellness programs and services.

- Call them at **1-800-922-2232**.
- Visit **anthem.com/statect** to find information just for you.

Health and wellness programs to help you take healthy steps

Lose weight, quit smoking. Control diabetes. Get help for autism and eating disorders. We have a full range of wellness programs, online tools and resources designed to meet your needs.

24/7 NurseLine is here for you

Health problems often happen when you least expect them. Call the 24/7 NurseLine at **1-800-711-5947** to talk with a registered nurse, who can answer questions about getting care. You can talk to the nurse about your symptoms, medicines and side effects, and reliable self-care home treatments.

When you need care right away

The emergency room (ER) shouldn't be your first stop — unless it's a true emergency. Depending on the situation, there are different types of providers you can see if your doctor isn't available. This includes a walk-in doctor's office, retail health clinic and urgent care center. Call the Enhanced Member Service Unit or go to **anthem.com/statect** to find care near you. **Note:** Call 911 or go to the ER if you think you could put your health at serious risk by delaying care.

When you need a helping hand

We offer programs if you or a family member needs behavioral health care or substance use disorder treatment. You can reach an Anthem Behavioral Health Care Manager by calling **1-888-605-0580**. To see how to access care, visit **anthem.com/statect**.

Access to care — wherever you go, we've got you covered

If you travel out of Connecticut, you have access to doctors and hospitals across the country with the BlueCard® program. Call **1-800-810-BLUE (2583)** to learn more. And, with the BlueCard® Worldwide program, you have access to providers in nearly 200 countries around the world.*

Manage your benefits online — and on the go

Log on at **anthem.com/statect** to find a doctor, check your claims and compare costs for care near you. If you haven't registered to use the website, choose **Register Now** and follow the steps. You can also download our free mobile app by searching for "Anthem Blue Cross and Blue Shield" at the App Store® or Google PlayTM. Use the app to show your ID card, get turn-by-turn directions to a doctor or urgent care, and much more!

SpecialOffers@Anthem

Go to **anthem.com/statect** to find special discounts on things that encourage healthy habits. This includes weight-loss programs, gym memberships, vitamins, glasses, contact lenses and much more.

[1] Blue Cross Blue Shield Association website, Coverage Home and Away (accessed March 2016): bcbs.com/already-a-member/coverage-home-and-away.html.

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Step up to better health

Comparing Plans: A Message From UnitedHealthcare

We are dedicated to helping people live healthier lives.

This is our mission and we take it seriously. By making healthier decisions, you can live a healthier life. It's that simple. Our programs and network can help you do just that.

Our Network

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

UnitedHealth Premium® designation

Choosing a doctor is one of the most important health decisions you'll make. The UnitedHealth Premium program can help you find doctors who are right for you and your family.

Choose with confidence.

The UnitedHealth Premium program evaluates physicians in various specialties using evidence- based medicine and national standardized measures to help you locate quality and cost-efficient providers. The UnitedHealth Premium program currently covers 16 specialty and 48 sub-specialty areas of medicine.

It's easier to find a UnitedHealth Premium Care Physician. Just go to **oxfordhealth.com** and select Members, which goes to a page that has "Find a Physician or Facility" listed under Links and Tools. Look for blue hearts.

If a doctor does not have a Premium designation, it does not mean he or she provides a lower standard of care. It could mean that the data available to us was not sufficient to include the doctor in the program. All doctors who are part of our network must meet our credentialing requirements (separate from the Premium program).

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 on general health information, deciding where to go for care, choosing self-care measures or guidance for difficult decisions.

Custom Website

We created this website for State of Connecticut employees and retirees to provide the tools and information to help you make informed health care decisions. Visit welcometouhc.com/stateofct to search for a doctor or hospital, or learn about the health plans we offer. You also can get Health Enhancement Program information at cthep.com, or by phone at 877-687-1448.

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

For information on discounts and special offers, please visit welcometouhc.com/stateofct.

Administrative services provided by Oxford
C. CT-15-206

Your Dental Plan Choices at a Glance

Cigna is the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and Dental HMO (DHMO).

	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% (network only)	Covered at 100%
Simple Restoration			
Fillings	Covered at 80%	Covered at 80%	Covered*
Oral Surgery	Covered at 67%	Covered at 80%	Covered*
Periodontal Maintenance	Covered at 80%	Covered at 100%[1]	Covered*
Other Periodontal Services	Covered at 50%	Covered at 80%	Covered*
Major Restoration			
Crowns	Covered at 67%	Covered at 67%	Covered*
Dentures, Fixed Bridges	Not covered**	Covered at 50%	Covered*
Implants	Not covered**	Covered at 50% (up to $500)	Covered*
Orthodontia	Not covered	Maximum of $1,500 per person per lifetime[5]	Covered*

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.

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

** 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 25 for details).

5 Benefits prorated over course of treatment.

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 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.

More details about covered expenses are available by contacting Cigna at 1-800-244-6224 or www.Cigna.com/stateofct.

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

Enhanced Plan Money-Saving Tip — Avoid Balance Billing

It pays to use network dentists if you are enrolled in the Enhanced Plan. Network dentists have agreed to discounted fees. Visit www.cigna.com/stateofct to find a network dentist.

If you use an out-of-network dentist, you will be subject to balance billing if your dentist charges more than the maximum allowable charge. For example, exams are covered at 100%; if you see a network dentist your exam is covered in full but if you see an out-of-network dentist you could still receive a bill.

Your 2017-2018 Dental Premium Share

Monthly Dental Premiums July 1, 2017 through June 30, 2018

COVERAGE LEVEL	Basic Plan	Enhanced Plan	DHMO Plan
1 Person	$33.94	$27.78	$30.78
2 Persons	$67.87	$55.55	$67.72
3 or More Persons	$67.87	$55.55	$83.12

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 26 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.

A Message **From Cigna**

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
- Cigna DHMO

We're there for you – when and how you need us.

Call us: 800.Cigna24 (800.244.6224)

Customer service hours include weekdays, Saturdays, Sundays and holidays. Call us at
800.Cigna24 (800.244.6224) anytime you need us – we'll be there. We're on the clock for you 24 hours a day, 7 days a week, 365 days a year.

Visit us online: Cigna.com/StateofCT

Customized website developed by Cigna just for State of CT employees, with:

- Information on plan specfics
- Help finding participating dentists and specialists
- Programs and plan features available to you

myCigna.com and myCigna App

Completely personalized, so it's easy to quickly find what you're looking for. Finding a dentist just got easier.

- Plan information
- Network directory of dentists
- Oral health assessments and quizzes
- Out-of-pocket dental cost estimates
- ID card information
- Claim information

Discounts on a variety of health and wellness products and services

Online tools for the DPPO network

If you enroll in a Basic or Enhanced Dental plan, we've created easy and intuitive online tools to help you make smart decisions about your dental care.

- Brighter Score™. Use this scoring method to help you compare dentists. The score is derived from factors such as affordability, patient experience and professional history. It's developed by Brighter.com.
- Read verifed patient reviews and detailed information to compare dental offices.
- Online appointment scheduling (for dentists who offer this service).
- Enhanced search and transparent pricing.

Coverage for Fillings under the Basic and Enhanced Plan

There's not always one simple answer for treating a dental condition. You and your dentist should discuss the various options, and then you can decide on the best approach. Your costs may vary based on the treatment plan you choose.

The Basic and Enhanced Plans provide coverage for amalgam (silver) fillings. If you decide to get a composite (white) filling, you'll be responsible for paying the dentist the difference between the silver filling covered by the plan and the more expensive restoration. Both of these methods are recognized by the dental profession as acceptable treatment plans; however, the silver filling is the least costly alternative for treatment.

Programs to Support Your Overall Health

Your health. Our focus.

In the real world, you have to balance your time, commitments and priorities. At Cigna, we keep our focus on helping you live healthier. Value-added programs such as wellness programs and discount savings are included with your Cigna dental plan.

Oral Health Integration Program®

Research shows an association between oral health and overall health.[1] By getting the right oral health care, along with regular medical treatments, high-risk individuals may be able to improve their overall health. Eligible State of Connecticut employees and retirees who enroll 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. The qualifying medical conditions for OHIP: heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head & neck cancer radiation.

For additional information regarding OHIP, please visit www.cigna.com/stateofct.

[1] Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Presented at the International Association for Dental Research Meeting March 2013, Seattle

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 Cigna.com/rewards (password savings) or calling 1.800.258.3312.

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

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. **We recommend that you contact Medicare to begin the enrollment process no later than 3 months prior to your 65th birthday.** 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 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 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 2017/2018 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

Retirement Health Insurance Open Enrollment Application

CO-744-OE REV. 7/2015

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 HEALTH INSURANCE UNIT

RETIREE LAST NAME (Person Receiving Benefit)	RETIREE 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 PPO 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

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)

ARE YOU PRESENTLY RECEIVING WORKERS' COMPENSATION? ☐ YES ☐ NO

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 and/or bill me as necessary for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE

CO-744-OE HEALTH BENEFITS OPEN ENROLLMENT

Forms must be postmarked by June 9, 2017.

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

Your Benefit Resources

For details about specific plan benefits and network providers, contact:			
Anthem Blue Cross and Blue Shield • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area • Anthem State Preferred POS (POS)	**www.Anthem.com/statect**	**1-800-922-2232**	
UnitedHealthcare (Oxford) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford 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**	

Nondiscrimination Policy

The Office of the State Comptroller complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Office of the State Comptroller does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Office of the State Comptroller:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
    - Provides free language services to people whose primary language is not English, such as:
        - > Qualified interpreters
        - > Information written in other languages

If you need these services, contact Ginger Frasca, Principal Human Resources Specialist.

If you believe that The Office of the State Comptroller has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ginger Frasca, Principal Human Resources Specialist, 55 Elm Street, Hartford CT 06106, (860) 702-3340, Fax (860) 702-3324, Ginger.Frasca@ct.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ginger Frasca, Principal Human Resources Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-860-702-3340.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-860-702-3340.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-860-702-3340.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-860-702-3340.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-860-702-3340.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-860-702-3340.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-860-702-3340.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-860-702-3340 पर कॉल करें।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-860-702-3340.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-860-702-3340.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-860-702-3340.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-860-702-3340.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-860-702-3340.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-860-702-3340.

Healthcare Policy & Benefit Services Division
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55 Elm Street
Hartford, CT 06106-1775

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New 2017-2018 premium shares.

See pages 5, 9 and 13 (depending on your retirement date).

RETIREES HEALTH CARE OPTIONS PLANNER

STATE OF CONNECTICUT

2017 | 2018