State of Connecticut

2019 Retiree Health Care Options Planner

Welcome

Welcome to Open Enrollment.

Our daily choices affect our health and how much we pay out of pocket for health care. Even if you're happy with your current coverage, it's a good idea to review your health care options each year during Open Enrollment so you understand how your coverage works and whether you need to make any changes.

All of the State of Connecticut health care 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 and your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

During this Open Enrollment period, we encourage you to take a few minutes to consider your options and choose the best value plan for you and your family. Everyone wins when you make smart choices about your health care.

Kevin Lembo
State Comptroller

Using Your Retiree Health Care Options Planner

This Planner is organized into coverage for non-Medicare-eligible individuals (starting on page 15) and coverage for Medicare-eligible individuals (starting on page 38). Within each section, benefit information is grouped by retirement date. Your retirement date falls into one of the following groups:

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 or later.

When reviewing your coverage options, be sure you are reading the correct section (Medicare-eligible or non-Medicare-eligible) and then make sure you are looking at the benefits for the correct retirement group. While you may be eligible for Medicare, and therefore enrolled in the UnitedHealthcare Group Medicare Advantage plan, your covered dependents may not be eligible for Medicare. If that is the case, they can choose a non-Medicare-eligible medical plan. Please pay careful attention to the differences between Medicare-eligible and non-Medicare-eligible coverage.

You may need to review coverage options in both the non-Medicare-eligible section and the Medicare-eligible section, depending on your and your dependents' Medicare eligibility.

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Your 2019 Open Enrollment Checklist

Open Enrollment is now through **June 14, 2019** for benefits effective July 1, 2019. Complete this list before the June 14 deadline to get a better understanding of the 2019 changes and to make updates to your coverage.

- ✓ Read this Retiree Health Care Options Planner.
- ✓ Review the premium amounts for medical and dental coverage on page 12 (even if you are not making any changes to your coverage elections).
- ✓ Pay careful attention to the What's New Starting July 1, 2019 section on page 2—it provides an overview of the 2019 changes to your health care coverage.
- ✓ If you decide to make changes, complete the Retiree Health Enrollment/Change Form (CO-744-OE) located on page 55 of this Planner. Be sure to:
  - Select the type of change you are requesting.
  - List all dependents you're covering and provide supporting documentation for new dependents.
  - Sign your application.
  - Cut out the application from the back of the Planner and return it via U.S. mail, email or fax to:

Office of the State Comptroller
ATTN: Retiree Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775

Email: **osc.rethealth@ct.gov**
Fax: 860-702-3556

If you have questions, call the Office of the State Comptroller, Retiree Health Insurance Unit at 860-702-3533. For more information about Open Enrollment, go to **www.osc.ct.gov**.

Important! After you review this Retiree Health Care Options Planner, if you decide **not** to make changes to your coverage, do **NOT** complete the Retiree Health Enrollment/Change Form (CO-744-OE). Your previous coverage elections will roll over automatically for 2019/2020 coverage, at the 2019/2020 premium contribution rates (as applicable).

What's New Starting July 1, 2019

All Retiree Coverage Changes

Medical and Dental Plan Premiums

Premiums for the medical and dental plans are changing. You can find information about the new retiree premiums starting on page 11.

New Stress-Free Digital Health Benefits

For Non-Medicare Retirees and Dependents, Anthem and UnitedHealthcare Oxford are now offering digital health care services through phone or video chat, including services to help manage stress, depression, grief and anxiety. These digital health care tools are designed to provide you with more immediate, convenient and affordable access to essential care that can be delivered remotely.

- For more on Anthem's LiveHealth Online, visit **livehealthonline.com**.
- For more on UnitedHealthcare Oxford's Able To program, call 844-622-5368.

For Medicare Retirees and Dependents, you have Virtual Doctor Visits. With this program, you're able use your computer, tablet or smartphone anytime, day or night for a live video chat with a doctor. You can ask questions, get a diagnosis, or even get medication prescribed and have it sent to your pharmacy. All you need is a strong internet connection.

Virtual Doctor Visits are great for treating:

- Allergies, bronchitis, cold/cough, pink eye, rash
- Fever, seasonal flu, sore throat, diarrhea
- Migraines/headaches, sinus problems, stomach ache.

Recap of 2018 Changes

Non-Medicare-Eligible Coverage Changes

SmartShopper

Retirees and enrolled dependents can use SmartShopper to shop for the highest quality care in Connecticut for a variety of procedures. Plus, after your claim is paid, you can receive a cash reward as high as $500. See page 24 for more information.

Site of Service for Outpatient Lab Services and Diagnostic Imaging

If you retired on or after October 2, 2017 and are in Retirement Group 5, you have a Preferred designation for outpatient lab services and diagnostic imaging (e.g., for blood work, urine tests, stool tests, x-rays, MRIs, CT scans). You'll pay nothing if you receive care at a Preferred lab or imaging facility—if you choose a Non-Preferred lab or imaging facility you'll pay 20% coinsurance. See page 23 for more information.

CVS/Caremark Standard Formulary

Retirees in Group 5 have a different CVS/Caremark formulary (that is, the covered drug list) than retirees in the other Groups. For more information on prescription drug costs and coverage, see page 29 or visit **www.caremark.com**.

Medicare-Eligible Coverage Changes

UnitedHealthcare® Group Medicare Advantage Plan

If you are a Medicare-eligible retiree, you and your Medicare-eligible dependents will be enrolled automatically in the UnitedHealthcare Group Medicare Advantage plan, regardless of the coverage you have today. See page 42 for information about this medical coverage.

2019 Open Enrollment Overview

Open Enrollment: now through June 14, 2019

Changes Effective: July 1, 2019 through June 30, 2020

Open Enrollment gives you the opportunity to change your health care benefit elections and your covered dependents for the coming plan year. It's a good time to take a fresh look at the plans available to you, consider how your and your family's needs may have changed, and choose coverage that offers the best value for your situation.

During Open Enrollment, you may change dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage. If you or a covered dependent is **not** eligible for Medicare, you can select a new non-Medicare-eligible health plan during the Open Enrollment period, too.

If you want to keep your current coverage elections, you do not need to complete the Retiree Health Enrollment/ Change Form (CO-744-OE). Your coverage will continue automatically.

If you are NOT eligible for Medicare...	If you are eligible for Medicare...
• Non-Medicare-eligible • Non-Medicare-eligible dependents of retirees	• Medicare-eligible retirees • Medicare-eligible dependents of retirees
You may enroll in or change your selection to one of these health plans:	You may NOT...
• Point of Service (POS) Plan – Anthem or Oxford • Point of Enrollment (POE) Plan – Anthem or Oxford • Point of Enrollment Gatekeeper (POE-G) Plan – Anthem or Oxford • Out-of-Area Plan – Anthem or Oxford • Preferred Point of Service (POS) Plan – Anthem only, closed to new enrollment	• Make a change to your medical coverage until the Medicare Open Enrollment in October 2019. You will get more information prior to the Medicare Open Enrollment period
You may...	You may...
• Enroll in or make changes to your non-Medicare-eligible medical plan (listed above) • Add or change your dental plan option • Add or drop dependents from medical and dental coverage	• Add or change your dental plan option • Add or drop dependents from medical and dental coverage
By submitting by June 14...	By submitting by June 14...
• A completed Retiree Health Enrollment/ Change Form (CO-744-OE) • Any required documentation supporting the addition of an eligible dependent	• A completed Retiree Health Enrollment/ Change Form (CO-744-OE) • Any required documentation supporting the addition of an eligible dependent

Once you choose a health plan, you cannot change plans until the next Open Enrollment. This is true even if your doctor or hospital leaves the health plan, unless you have a qualifying status change, such as moving out of the plan's service area or becoming eligible for Medicare (in which case you must enroll in the UnitedHealthcare Group Medicare Advantage plan). More information about qualifying status changes is on page 8.

Enrolling in Retiree Health Benefits

2019 Open Enrollment is now through June 14 for coverage effective July 1, 2019 through June 30, 2020.

Current Retirees

Retirees and/or dependents who are Medicare-eligible are enrolled automatically in the UnitedHealthcare Group Medicare Advantage (PPO) plan. Medicare-eligible retirees and/or dependents do **not** need to complete an enrollment form unless changing dental coverage or your covered dependents.

If you want to make changes to your or your dependents' dental coverage or non-Medicare-eligible medical coverage (if applicable), follow the Open Enrollment Checklist, on page 1. Fill out the Retiree Health Enrollment/Change Form (CO-744-OE) located on page 55 of this Planner and return it to the Retiree Health Insurance Unit.

Questions about retiree health benefits? Call the Office of the State Comptroller, Retiree Health Insurance Unit at 860-702-3533 or email your question to **www.osc.ct.gov**.

Retirees and dependents may be enrolled in different plans, depending on Medicare eligibility. All State of Connecticut Health Plan members who are eligible for Medicare are enrolled automatically in the UnitedHealthcare Group Medicare Advantage (PPO) plan. If you have enrolled dependents who are not yet eligible for Medicare (typically, those under age 65), their current medical and prescription drug coverage will stay the same. This means that some retirees and dependents will be enrolled in different plans. This is also referred to as a "split family."

New Retirees

Your health coverage as an active employee does NOT automatically transfer to retirement coverage. You **must** enroll to have retiree health coverage for you and any eligible dependents. To enroll for the first time, follow these steps:

- Review this Planner and choose the medical and dental options that best meet your needs. Note: If you are Medicare-eligible, there is only one medical plan option.
- Complete the Retiree Health Enrollment/Change Form (CO-744), included in your retirement packet. **Note: This is different from the form included in the back of this Planner.**
- Return the completed form and any necessary supporting documentation to the Office of the State Comptroller at the address shown on the form.

The Retiree Health Enrollment/Change Form (CO-744-OE) is available on page 55 of this Planner and online at **www.osc.ct.gov**.

You must complete your enrollment in retiree health coverage within **31 calendar days** after your retirement date. If you do not enroll within 31 days, you must wait until the next Open Enrollment to enroll in retiree coverage.

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.

Important! If you are Medicare-eligible, you must be enrolled in Medicare to enroll in the State of Connecticut Retiree Health Plan. If you are age 65 or older, contact Social Security **at least three months** before your retirement date to learn about enrolling in Medicare.

Waiving Coverage

If you waive coverage when you're initially eligible, you may enroll within 31 days of losing your other coverage, or during any Open Enrollment period. Retirees who do not want coverage must complete the Retiree Health Enrollment/Change Form (CO-744-OE), check "Waive Medical Coverage," and return it to the Retiree Health Insurance Unit.

Important! If you waive retiree coverage, either non-Medicare-eligible or Medicare-eligible, you **cannot** cover any dependents under the State of Connecticut Retiree Health Plan. You must be enrolled in order to cover your eligible dependents.

Eligibility for Retiree Health Benefits

Retiree

You must meet age and minimum service requirements to be eligible for retiree health coverage. Service requirements vary. For more about eligibility for retiree health benefits, contact the Retiree Health Insurance Unit at 860-702-3533.

Dependent

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 enroll a person who is not eligible, you will have to pay Federal and State taxes on the fair market value of benefits provided to that individual.**

Eligible dependents generally include:

- Your legally married spouse or civil union partner
- Eligible children, including natural, adopted, stepchildren, legal guardianship and court-ordered children, until the end of the year the child turns age 26 for medical and until age 19 for dental. Note: Children residing with you for whom you are the legal guardian or under a court order are eligible for coverage up to age 19, unless proof of continued dependency is provided.

Disabled children may be covered beyond age 26 for medical and age 19 for dental. For your disabled child to remain an eligible dependent, he/she must be certified as disabled by your insurance carrier before his/her 26th birthday for medical coverage and his/her 19th birthday for dental coverage. Your disabled child must meet the following requirements for continued coverage:

- Adult child is enrolled in a State of Connecticut employee plan on the child's 26th birthday for medical coverage and 19th birthday for dental coverage. (Not required if you are a new retiree enrolling for the first time.)
- Disabled child must meet the requirements of being an eligible dependent child before turning 26 for medical coverage and 19 for dental coverage. (Not required if you are a new retiree enrolling for the first time.)
- Adult child must have been physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled since age 26 for medical coverage and 19 for dental coverage.
- Adult child is dependent on the member for substantially all of their economic support and is declared as an exemption on the member's federal income tax.
- Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter and upon request.
- All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify the Retiree Health Insurance Unit of any dependent's eligibility for, and enrollment in, Medicare.

Once enrolled, the member must continuously enroll the disabled adult child in the State of Connecticut Retiree Health Plan and Medicare (if eligible) to maintain future eligibility.

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

New for 2019!
Dependent children are covered for the remainder of the calendar year after they turn age 26.

Retiree members and dependents covered by the State of Connecticut Retiree Health Plan must be enrolled in Medicare as soon as they are eligible due to age, disability, or End Stage Renal Disease (ESRD).

For information about documentation required for enrolling a new dependent or making changes to your coverage outside of Open Enrollment, see *Making Changes to Your Coverage During the Year* on page 8.

Making Changes to Your Coverage During the Year

Once you choose your medical (if enrolled in non-Medicare-eligible coverage) and dental plans, you cannot make changes during the plan year (July 1 – June 30) unless you have a "qualifying status change," as defined by the IRS.

If you have a qualifying status change, you must notify the Retiree Health Insurance Unit **within 31 days after the event**, and submit a Retiree Health Enrollment/Change Form (CO-744). If the required information is not received within 31 days, you must wait until the next Open Enrollment to make the change.

The change you make must be consistent with your change in status. Qualifying status changes and the documentation you must submit for each change are shown on the next page.

Review Your Dependent Coverage

If an enrolled dependent is no longer eligible for coverage under the State of Connecticut Retiree Health Plan, you **must** notify the Retiree Health Insurance Unit immediately. If you are legally separated or divorced, your spouse/former spouse is **not** eligible for coverage.

Qualifying Status Change	Required Documents	Coverage Date
Marriage or Civil Union	• Completed Enrollment Application • Copy of a marriage certificate (issued in the United States) • Birth certificate for any of your spouse's children you plan to cover • A Social Security number for anyone you are adding to your coverage • Proof of Medicare enrollment (if applicable)	First day of the month following the event date
Birth or Adoption	• Completed Enrollment Application • Copy of the birth certificate or adoption documentation	Newborn child: First of the month following the child's date of birth Adopted child: The date the child is placed with you for adoption
Legal Guardianship or Court Order	• Completed Enrollment Application • Documentation of legal guardianship or court order	The first day of the month following the submission of proof of the event or court order
Divorce or Legal Separation	• Completed Enrollment Application • Copy of the legal documentation of your family status change	Coverage will terminate on the first day of the month following the date in which the divorce or legal separation occurred
By law, you must disenroll ineligible dependents within 31 days after the date of a divorce or legal separation. Failure to notify the Retiree Health Insurance Unit can result in significant financial penalties.		
Loss of Other Health Coverage	• Completed Enrollment Application • Proof of loss of coverage (documentation must state the date your other coverage ends and the names of individuals losing coverage)	First of the month following your loss of coverage
Obtaining Other Health Coverage	• Completed Enrollment Application • Proof of enrollment in other health coverage (documentation must indicate the effective date of coverage and the names of enrolled individuals)	Coverage will terminate on the first of the month following the event date. Note: You must pay premium contributions up to the termination date of your retiree health coverage
Moving Out of Your Plan's Service Area (non-Medicare-eligible coverage only)	• Address Change Form (form CO-1082), available on **www.osc.ct.gov**	Coverage under the new plan will be effective the first of the month following the date you permanently moved
If you or a covered dependent has Medicare-eligible coverage, you must live in the U.S. in order to be covered by the Plan.		
Death of a Dependent	• Copy of the death certificate	Coverage terminates the day after the dependent's death

Death of a Retiree

If you die, your surviving dependents or designee should contact the Retiree Health Insurance Unit to obtain information about their eligibility for survivor health benefits. To be eligible for health benefits, your surviving spouse must have been married to you at the time of your retirement and he/she must continue to receive your pension benefit after your death. After the Retiree Health Insurance Unit is notified of your death, your surviving spouse will receive further information.

Changes in Premiums

Change in coverage due to a qualifying status change may change your premium contributions. Review your pension check to make sure premium deductions are correct. If the premium deduction is incorrect, contact the Retiree Health Insurance Unit. You must pay any premiums that are owed. Unpaid premium contributions could result in termination of coverage.

Cost of Coverage

Once you are enrolled, premium contributions are deducted from your monthly pension check. Review your pension check to verify that the correct premium contribution is being deducted. If your pension check does not cover your required premiums or you do not receive a pension check, you will be billed monthly for your premium contributions. Premium contribution deductions are shown on page 12.

All Medicare-eligible retirees and dependents must maintain continuous enrollment in Medicare. To ensure there is no break in your medical coverage, you must pay all Medicare premiums that are due to the federal government on time. You will continue to be reimbursed for your Medicare Part B and IRMAA premium amounts as long as the State has a copy of your Medicare card and annual premium notice on file.

Calculating Your Medical Premium Contribution Rate

All Covered Individuals Eligible for Medicare

If you and all covered dependents are eligible for Medicare, you will pay nothing for your medical and prescription drug coverage offered through the State of Connecticut Retiree Health Plan.

Split Families

If you have "split family" coverage—coverage where one or more members are eligible for Medicare and one or more members are not eligible for Medicare—you will need to calculate how much you will pay for coverage on a monthly basis. Here's how:

1. You will pay nothing for Medicare-eligible individuals enrolled in medical and prescription drug coverage under the State of Connecticut Retiree Health Plan.
2. For all non-Medicare-eligible individuals, you will only pay medical premium contributions if they are enrolled in one of the plans that requires monthly premium contributions.

   Review the *Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage* section on page 12 to see if you or your dependents are covered under a plan that requires premiums. If yes, determine your monthly premium amount by identifying the number of individuals covered under that plan.

All Covered Individuals Not Eligible for Medicare

You will only pay medical premium contributions if you and your dependents are enrolled in one of the plans that requires monthly premium contributions.

Review the *Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage* section on the following page to see if you or your dependents are covered under a plan that requires premiums. If yes, determine your monthly premium amount by identifying the number of individuals covered under that plan.

Monthly Medical Premium Contributions for Non-Medicare-Eligible Coverage

	Point of Enrollment – Gatekeeper (POE-G) Plans		Point of Enrollment (POE) Plans	
Coverage Level	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select
Group 1: Retirement Date Prior to July 1999				
1 person	$0	$0	$0	$0
2 persons	$0	$0	$0	$0
3 + persons	$0	$0	$0	$0
Group 2: Retirement Date 7/1/99 – 5/1/09, and those under the 2009 RIP				
1 person	$0	$0	$0	$0
2 persons	$0	$0	$0	$0
3 + persons	$0	$0	$0	$0
Group 3: Retirement Date 6/1/09 – 10/1/11				
1 person	$0	$0	$0	$0
2 persons	$0	$0	$0	$0
3 + persons	$0	$0	$0	$0
Group 4: Retirement Date 10/2/11 – 10/1/17				
1 person	$0	$0	$0	$0
2 persons	$0	$0	$0	$0
3 + persons	$0	$0	$0	$0
Group 5: Retirement Date 10/2/17 or Later; 25 years of service or more OR Hazardous Duty				
1 person	$0	$0	$0	$0
2 persons	$0	$0	$0	$0
3 + persons	$0	$0	$0	$0
Group 5: Retirement Date 10/2/17 or Later; fewer than 25 years of service OR Non-Hazardous Duty				
1 person	$16.18	$16.75	$16.32	$16.84
2 persons	$35.59	$36.85	$35.90	$37.05
3 + persons	$43.68	$45.23	$44.06	$45.47

Higher Premiums Without HEP. If your retirement date is October 2, 2011 or later, you are eligible for the Health Enhancement Program (HEP). See page 26. If you choose not to enroll in HEP, or enroll but do not meet the HEP requirements, your monthly premium share will be $100 higher than shown above. To change your HEP enrollment status, you may complete the Health Enhancement Program Enrollment Form (Form CO-1314), available at **www.osc.ct.gov** or from the Retiree 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 Retiree Health Insurance Unit at 860-702-3533.

Point of Service (POS) Plans			Out-of-Area Plans	
Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem Out-of-Area	UnitedHealthcare Oxford Out-of-Area
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
$17.57	$17.82	$18.16	$0	$0
$38.66	$39.21	$39.95	$0	$0
$47.45	$48.12	$49.03	$0	$0
$17.57	$17.82	$18.16	$0	$0
$38.66	$39.21	$39.95	$0	$0
$47.45	$48.12	$49.03	$0	$0
$17.57	$18.63	$18.16	$0	$0
$38.66	$40.98	$39.95	$0	$0
$47.45	$50.29	$49.03	$0	$0
$16.62	$17.65	$17.19	$0	$0
$36.56	$38.82	$37.82	$0	$0
$44.87	$47.65	$46.42	$0	$0
$33.24	$35.29	$34.39	$17.75	$16.73
$73.13	$77.65	$75.65	$39.06	$36.81
$89.75	$95.29	$92.84	$47.93	$45.18

*Closed to new enrollment.

Monthly Dental Premium Contributions

You'll pay for the cost of dental coverage through deductions from your monthly pension check. Your premium contribution depends on the dental plan you choose, your retirement date and the number of covered individuals.

Coverage Level	Basic Plan	Enhanced Plan	DHMO Plan
All Retirement Groups			
1 person	$41.18	$33.70	$29.86
2 persons	$82.35	$67.41	$65.70
3 + persons	$82.35	$67.41	$80.63

Coverage for Individuals Not Eligible for Medicare

Non-Medicare-eligible coverage is only for non-Medicare-eligible retirees and non-Medicare-eligible dependents (of either non-Medicare-eligible or Medicare-eligible retirees). If you are eligible for Medicare, please skip to *Coverage for Individuals Eligible for Medicare*, which begins on page 38.

In general, the plans and coverage available to non-Medicare-eligible retirees and dependents is the same. However, certain copays and prescription drug programs vary based on your retirement date. Be sure to review the coverage for your retirement group.

Medical Coverage

As a non-Medicare-eligible retiree or dependent, you have access to the same medical plans you had as an active employee:

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 Out-of-Area • UHC Oxford Out-of-Area Available to those permanently living outside of Connecticut.

**Closed to new enrollment.*

When it comes to choosing a medical plan, there are five main areas to consider:

- **What is covered:** the services and supplies that are considered covered expenses under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies.
- **Cost:** what you pay when you receive medical care and what is deducted from your pension check for the cost of having coverage. What you pay at the time you receive services is similar across the plans. However, your premium share (that is, the amount you pay to have coverage) varies substantially, depending on the carrier and plan selected.
- **Networks:** whether your doctor or hospital has contracted with the insurance carrier to be a "network provider." If your plan offers in- and out-of-network coverage, you'll pay less for most services when you receive them in-network. That's because in-network providers discount their fees, based on contractual arrangements they have with the medical insurance carrier. If your plan does not offer in- and out-of-network coverage, you will not receive any benefits for services received outside the network (except in cases of emergency).

- **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. Plus, certain plans require you to have a Primary Care Physician and receive referrals for in-network specialists.
- **Health promotion:** all of the plans offer health information online; some offer additional services, such as 24-hour nurse advice lines and health risk assessment tools.

The table below helps you compare all your medical plan options based on the differences.

	Point of Enrollment – Gatekeeper (POE-G) Plans	Point of Enrollment (POE) Plans	Point of Service (POS) Plans	Out-of-Area Plans
National network	X	X	X	X
Regional network	X	X	X	X
In- and out-of-network coverage available			X	X
In-network coverage only (except in emergencies)	X	X		
No referrals required for care from in-network providers		X	X	X
Primary care physician (PCP) coordinates all care	X			

Medical Coverage At-a-Glance

The table below and on the following pages shows the coverage available under the various medical plan options. As a reminder, the retirement groups are:

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 or later.

Benefit Features	In-Network POE, POE-G, POS, OOA Both Carriers		
	Group 1	Group 2	Group 3
Annual deductible	None	None	None
Annual medical out-of-pocket maximum	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000
Pre-admission authorization/ concurrent review	Through participating provider	Through participating provider	Through participating provider
Primary Care Physician office visit			
Preferred provider[1]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Preferred provider	$5	$15	$15
Specialist office visit			
Preferred provider[1]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Non-Preferred provider	$5	$15	$15
Preventive services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Emergency care	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient diagnostic imaging and lab	Plan pays 100%	Plan pays 100%	Plan pays 100%

[1] *You may be eligible for a $0 copay by using a Preferred PCP or Specialist within 10 Specialties.*

In-Network POE, POE-G, POS, OOA Both Carriers		Out-of-Network POS, OOA Both Carriers
Group 4	**Group 5**	**All Groups**
Individual: $350[2] Family: $350 per individual; $1,400 maximum per family[2]	Individual: $350[2] Family: $350 per individual; $1,400 maximum per family[2]	Individual: $300 Family: $300 per individual; $900 maximum per family
Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $2,300 Family: $4,900
Through participating provider	Through participating provider	Penalty of 20% up to $500 for no authorization
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[3]
$15	$15	
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[3]
$15	$15	
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[3]
$35[4]	$250[4]	Same copay as in-network
Plan pays 100%	Preferred Site of Service: Plan pays 100% Non-Preferred Site of Service: 20% coinsurance, Plan pays 80%	**Groups 1 – 4:** 20% coinsurance, Plan pays 80%[3] **Group 5**: Preferred Site of Service: 20% coinsurance, Plan pays 80% Non-Preferred Site of Service: 40% coinsurance, Plan pays 60%

[2] *Waived for HEP-compliant members.*

continued on next page

[3] *You pay 20% of the allowable charge after the annual deductible, plus 100% of any amount your provider bills over the allowable charge (balance billing).*

[4] *Emergency room copay waived if admitted; waiver form available for certain circumstances: **www.osc.ct.gov.***

Benefit Features	In-Network POE, POE-G, POS, OOA Both Carriers		
	Group 1	Group 2	Group 3
Inpatient hospital care[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Skilled nursing facility (SNF)[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient surgery[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Short-term rehabilitation and physical therapy[6]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Pre-admission testing	Plan pays 100%	Plan pays 100%	Plan pays 100%
Ambulance (if emergency)	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient mental health and substance abuse treatment[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient mental health and substance abuse treatment[5]	$15 copay	$15 copay	$15 copay
Durable medical equipment[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Prosthetics[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Home health care[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Hospice[5]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Routine hearing exam (1 exam per year)	$15 copay	$15 copay	$15 copay
Hearing aids[5] (one set within a 36-month period)	Plan pays 100%	Plan pays 100%	Plan pays 100%
Routine vision exam (1 exam per year)	$15 copay	$15 copay	$15 copay

[5] *Prior authorization may be required.*

[6] *Subject to medical necessity review.*

In-Network POE, POE-G, POS, OOA Both Carriers		Out-of-Network POS, OOA Both Carriers
Group 4	**Group 5**	**All Groups**
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[7]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80% (up to 60 days/year)[2]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[7]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80% (up to 60 inpatient days per condition per year; 30 outpatient days per condition per year)[3]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[7]
Plan pays 100%	Plan pays 100%	Plan pays 100%
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[7]
$15 copay	$15 copay	20% coinsurance, Plan pays 80%[7]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[7]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%[7]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80% (up to 200 visits/year)[3]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80% (up to 60 days per lifetime)[3]
$15 copay	$15 copay	20% coinsurance, Plan pays 80%[7]
Plan pays 100%	Plan pays 100%	20% coinsurance, Plan pays 80%
$15 copay[8]	$15 copay[8]	50% coinsurance, Plan pays 50%

[7] *You pay 20% of the allowable charge after the annual deductible, plus 100% of any amount your provider bills over the allowable charge (balance billing).*

[8] *HEP participants have $15 copay waived once every two years.*

Preferred Provider Networks

For non-Medicare retirees and dependents, Anthem and UnitedHealthcare/Oxford have two designations for in-network providers: Preferred and Non-Preferred. You can see any in-network primary care provider (PCP) or specialist and pay a copay; however, if you see an in-network Preferred provider, the copay will be waived—you'll pay nothing! In-network Preferred specialists are currently available for ten medical specialties:

- Allergy and immunology
- Cardiology
- Endocrinology
- Ear, nose and throat (ENT)
- Gastroenterology
- OB/GYN
- Ophthalmology
- Orthopedic surgery
- Rheumatology
- Urology.

To find an in-network Preferred provider or facility, visit:

- **www.anthem.com/statect** (for Anthem) or
- **www.welcometouhc.com/stateofct** (for UnitedHealthcare/Oxford).

The Cost of In-Network Preferred vs. Non-Preferred Care

The table below shows how much you will pay for care when you visit an in-network Preferred provider, as compared to an in-network Non-Preferred provider.

	If You See an In-Network *Preferred* Provider	If You See an In-Network *Non-Preferred* Provider
In-Network	Yes	Yes
Your Copay	$0 copay	$5 – $15 copay (depending on your retirement date, see pages 18 and 19)
Preventive Care	$0 copay	$0 copay
Primary Care Providers (PCP)	$0 copay; Select from list of Preferred in-network PCPs	$5 – $15 copay (depending on your retirement date, see pages 18 and 19); all in-network PCPs
Specialists	$0 copay; select from list of Preferred in-network specialists in one of ten medical specialties	$5 – $15 copay (depending on your retirement date, see pages 18 and 19); all in-network specialists

For Group 5 Only—Preferred Providers (Site of Service) for Outpatient Lab Tests and Imaging

If you are in Retirement Group 5, there is also a *Preferred* designation for outpatient lab services and diagnostic imaging (e.g., for blood work, urine tests, stool tests, x-rays, MRIs, CT scans). You'll pay nothing if you receive care at a Preferred lab or imaging facility! Otherwise, you'll pay 20% of the cost for care received at an in-network Non-Preferred lab or imaging facility, or 40% of the cost for out-of-network facilities (POS Plan only), as summarized below.

Preferred In-Network Facility	Non-Preferred In-Network Facility	Out-of-Network Facility (POS Plan Only)
$0 copay; Plan pays 100%	20% coinsurance; Plan pays 80%	40% coinsurance; Plan pays 60%

If you are not in Retirement Group 5, you do not have a special designation for outpatient lab tests and imaging. Coverage will be provided according to the table on pages 18 and 19.

Medical Necessity Review for Therapy Services

Physical and occupational therapy services are subject to medical necessity review—a determination indicating if your care is reasonable, necessary and/or appropriate based on your needs and medical condition. If you see an in-network provider, it is the provider's responsibility to submit all necessary information during the medical necessity review process.

SmartShopper

SmartShopper is available to all State of Connecticut Non-Medicare retirees and their enrolled dependents. Health care quality and cost can vary significantly depending on the provider you choose and where you receive care.

SmartShopper encourages you to be a smart health care consumer by helping you to shop for medical services, find the highest quality care in Connecticut and earn cash rewards! SmartShopper can help you find high-quality care for hip and knee replacements, bariatric surgeries, hysterectomies, back and spine problems, and more.

Using SmartShopper

Just follow these three simple steps when your doctor recommends a medical test, service or procedure.

1. **Shop.** Contact SmartShopper over the phone or online at the contact information below. They'll help you find the highest-quality care for your medical procedure. Plus, they'll schedule it for you!
2. **Go.** Have your procedure at the location of your choice.
3. **Earn.** Once your procedure is complete and your claim is paid, a reward check is mailed to your home. There's nothing you have to do to receive your reward.

For more information or to activate your secure SmartShopper account, call SmartShopper at 844-328-1579 or visit **vitalssmartshopper.com**.

Additional Programs

Additional programs are provided outside the contracted plan benefits. They're provided by each carrier to help the carrier differentiate their plan(s) from those of other carriers. Because these programs are not plan benefits, they are subject to change at any time by the insurance carrier.

Anthem BlueCross BlueShield's Additional Programs

- **Health and wellness programs.** Anthem has a full range of wellness programs, online tools and resources designed to meet your needs. Wellness topics include weight loss, smoking cessation, diabetes control, autism education and assistance with managing eating disorders.
- **24/7 NurseLine.** The 24/7 NurseLine provides answers to health-related questions, provided by a registered nurse. You can talk to the nurse about your symptoms, medicines and side effects, and reliable self-care home treatments. To reach the NurseLine, call 800-711-5947.
- **Anthem Behavioral Health Care Manager.** Call an Anthem Behavioral Health Care Manager when you or a family member needs behavioral health care or substance abuse treatment: 888-605-0580. To see how to access care, visit anthem.com/statect.
- **BlueCard® and BlueCard Worldwide.** You have access to doctors and hospitals across the country with the BlueCard® program. With the BlueCard® Worldwide program, you have access to network providers in nearly 200 countries around the world. Call 800-810-BLUE (2583) to learn more.
- **Online access to network provider information, claims and cost-comparison tools.** Visit anthem.com/statect to find a doctor, check your claims and compare costs for care near you. If you haven't registered on the site, choose Register Now and follow the steps. Download the free mobile app by searching for "Anthem Blue Cross and Blue Shield" at the App Store® or on Google Play™. Use the app to show your ID card, get turn-by-turn directions to a doctor or urgent care, and more.
- **Special offers.** Go to anthem.com/statect to find special health-related discounts, including for weight-loss programs, gym memberships, vitamins, glasses, contact lenses and more.

UnitedHealthcare/Oxford's Additional Programs

- **Oxford On-Call® 24/7 Healthcare Guidance.** 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. Call 800-201-4911 and press option 4.
- **UnitedHealthcare Choice Plus Network.** Nationally and in the tri-state area, UnitedHealthcare has a large number of doctors, health care professionals and hospitals. You have access to care whether you are in Connecticut, traveling outside the tri-state area or living somewhere else in the country.
- **Welcometouhc.com/stateofct.** Visit welcometouhc.com/stateofct to search for a doctor or hospital, or learn about the health plans offered by UnitedHealthcare.
- **UnitedHealthcare Discounts.** For information on discounts and special offers, visit welcometouhc.com/stateofct.

Health Enhancement Program (HEP)

The Health Enhancement Program (HEP) encourages you to take an active role in your health by getting age-appropriate wellness exams and screenings. **Retirees in Group 4 or Group 5, and their enrolled dependents, are eligible for the Health Enhancement Program (HEP). The retirement dates for those groups are:**

- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 or later.

If you're a HEP participant and complete the HEP requirements as indicated in the chart on page 27, you qualify for lower monthly premiums and reduced copays. You also won't pay a deductible when you receive in-network care. It's your choice whether or not to participate in HEP, but there are many advantages to doing so.

Enrolling in HEP

New Retirees

If you are a new retiree who was enrolled in HEP as an active employee when you retired, you do not have to enroll in HEP—your current HEP enrollment will continue. If you're **not** currently enrolled in HEP and would like to enroll, you must complete the HEP Enrollment Form (form CO-1314) when you make your benefit elections. HEP Enrollment Forms are available from the Retiree Health Insurance Unit at **www.osc.ct.gov** or by calling 860-702-3533. If you don't want to continue HEP participation, you can disenroll during Open Enrollment.

Current Retirees

If you are a current retiree **not** participating in HEP, you can enroll during Open Enrollment. Forms are available from the Retiree Health Insurance Unit at **www.osc.ct.gov** or by calling 860-702-3533.

Continuing Your HEP Enrollment

If you participate in HEP and successfully meet all of the annual HEP requirements, you are re-enrolled automatically the following year and continue to pay lower premiums for health care coverage.

HEP Requirements

To meet HEP requirements, you, your enrolled spouse and your enrolled dependents must get age-appropriate wellness exams and early diagnosis screenings (e.g., colorectal cancer screenings, Pap tests, mammograms, vision exams), as shown in the table below.

Preventive Screenings	Age						
	0-5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Doctor's Office Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 3 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+: 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	20+: Every 5 years	Every 5 years	Every 5 years	Every 5 years	Every 2 years
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	21+: Every 3 years	Every 3 years	Every 3 years	Every 3 years	50 – 65: 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 to age 75

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

***Or as recommended by your physician.*

Additional HEP Requirements for Those with Certain Chronic Conditions

If you or any of your enrolled family members have one of the following health conditions, you and/or that family member must participate in a disease education and counseling program to meet HEP requirements.

- Diabetes (Type 1 or 2)
- Asthma or COPD
- Heart disease/heart failure
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure).

Doctor office visits will be at no cost to you and your pharmacy copays will be reduced for treatment related to your condition. Your household must meet all preventive and chronic care requirements to receive HEP benefits.

You can also call WellSpark Health to speak with a representative. See page 57 for contact information.

More Information About HEP

Visit the HEP portal at **www.cthep.com** to find out whether you have outstanding dental, medical or other requirements to complete. If you or an enrolled dependent has a chronic condition, you/they can also complete chronic condition requirements online. Any medical decisions will continue to be made by you/your enrolled dependents and your/their physician.

WellSpark Health (formerly known as Care Management Solutions), an affiliate of ConnectiCare, administers 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(s)
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals.

Prescription Drug Coverage

No matter which medical plan you choose, your non-Medicare prescription drug coverage is provided through CVS/Caremark. The plan has a four-tier copay structure. This means the amount you pay for prescription drugs depends on whether your prescription is for a preferred generic drug, a generic drug, a brand name drug listed on Caremark's preferred drug list (the formulary), or a non-preferred brand name drug. The amount you pay also depends on where you fill your medication and when you retired, as shown in the following tables.

In-Network Prescription Drug Coverage

	Groups 1 and 2		Group 3	
	Acute and Maintenance Drugs (up to a 90-day supply)	Caremark Mail Order/ Maintenance Drug Network* (90-day supply)	Acute and Maintenance Drugs (up to a 90-day supply)	Caremark Mail Order/ Maintenance Drug Network* (90-day supply)
Tier 1: Preferred Generic	$3	$0	$5	$0
Tier 2: Generic	$3	$0	$5	$0
Tier 3: Preferred Brand	$6	$0	$10	$0
Tier 4: Non-Preferred Brand	$6	$0	$25	$0

**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 copay.*

	Group 4			Group 5*		
	Acute Drugs (up to a 90-day supply)	Maintenance Drugs (90-day supply)**	HEP Enrolled***	Acute Drugs (up to a 90-day supply)	Maintenance Drugs (90-day supply)**	HEP Enrolled***
Tier 1: Preferred Generic	$5	$5	$0	$5	$5	$0
Tier 2: Generic	$5	$5	$0	$10	$10	$0
Tier 3: Preferred Brand	$20	$10	$5	$25	$25	$5
Tier 4: Non-Preferred Brand	$35	$25	$12.50	$40	$40	$12.50

**Retirees in Group 5 have a different CVS/Caremark formulary (that is, the covered drug list), than retirees in the other Groups. The CVS/Caremark Standard Formulary is focused on clinically effective lower-cost alternatives to high-cost drugs.*

***You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order.*

****Maintenance drugs to treat 1) asthma or COPD; 2) diabetes (Type 1 or 2); 3) heart failure/heart disease; 4) hyperlipidemia (high cholesterol); or 5) hypertension (high blood pressure): You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order.*

Out-of-Network Prescription Drug Coverage

All Retirement Groups	
Tier 1: Preferred Generic	20% of prescription cost
Tier 2: Generic	20% of prescription cost
Tier 3: Preferred Brand	20% of prescription cost
Tier 4: Non-Preferred Brand	20% of prescription cost

Prescription Drug Tiers

A drug's tier placement is determined by CVS/Caremark and is reviewed quarterly. If new generics have become available, new clinical studies have been released or new brand name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

Prescription Drug Programs

Your prescription drug coverage has the following programs to encourage the use of safe, effective and less costly prescription drugs.

- **Mandatory Generics.** Your prescription will be filled automatically with a generic drug if one is available, unless your doctor completes CVS/Caremark's Coverage Exception Request Form and the form is approved by CVS/Caremark. **(It is not enough for your doctor to note "dispense as written" on your prescription; completion of the Coverage Exception Request Form is required.)**

  If you request a brand name drug instead of a generic alternative without obtaining a coverage exception, you will pay the generic drug copay **PLUS** the difference in cost between the brand and generic drug.
- **CVS/Caremark Specialty Pharmacy.** Treatment of certain chronic and/or genetic conditions require special pharmacy products, which are often injected or infused. The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 800-237-2767 for information.

Tips for Reducing Your Prescription Drug Costs

- **Compare and contrast prescription drug costs.** Contact CVS/Caremark to find the tier of the prescription drugs you and your family members use. If you have any Tier 3 or Tier 4 drugs, consider speaking with your doctor about switching to a generic equivalent.
- **Use the Maintenance Drug Network or the Mail Service Pharmacy.** If you are taking a maintenance medication for a long-term condition, such as asthma, high blood pressure or high cholesterol, switch your prescription from a retail pharmacy to the Maintenance Drug Network or the Mail Service Pharmacy. Once you begin using the Mail Service Pharmacy, you can conveniently order refills by phone or online. Contact CVS/Caremark for more information.

Dental Coverage

Cigna is the dental carrier for the State of Connecticut's three dental plans:

- **Basic Plan.** This plan allows you to visit any dentist or dental specialist without a referral.
- **Enhanced Plan.** This plan also allows you to visit any dentist or dental specialist without a referral, but pays a different level of benefits than the Basic Plan.
- **DHMO® Plan (DHMO).** This plan provides dental services only from a defined network of dentists and pays benefits only when you receive care from a network dentist (except in cases of emergency). You must select a Primary Care Dentist. He/she will coordinate your care. Referrals are required for all specialist services.

Many of the Basic and Enhanced Plan network dentists have agreed to offer their discounted fees to you and your enrolled dependents for non-covered services. You must visit network dentists to receive the discounts (savings will not apply for care received from non-participating dentists). Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. 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.

Dental Coverage At-a-Glance

	Basic Plan	Enhanced Plan	DHMO Plan
Annual deductible	None	Individual: $25 Family: $75 The deductible does not apply to routine exams, cleanings and x-rays	None
Annual benefit maximum	None; $500 per person for periodontics	$3,000 per person; excluding orthodontia	None
Routine exams, cleanings, x-rays	Plan pays 100%	Plan pays 100%[1]	Covered[3]
Periodontal maintenance[2]	20% coinsurance, Plan pays 80% (If enrolled in HEP covered at 100%)	Plan pays 100%[1]	Covered[3]
Periodontal root scaling and planing[2]	50% coinsurance, Plan pays 50%	20% coinsurance, Plan pays 80%	Covered[3]
Other periodontal services	50% coinsurance, Plan pays 50%	20% coinsurance, Plan pays 80%	Covered[3]
Simple restorations			
Fillings	20% coinsurance, Plan pays 80%	20% coinsurance, Plan pays 80%	Covered[3]
Oral surgery	33% coinsurance, Plan pays 67%	20% coinsurance, Plan pays 80%	Covered[3]
Major restorations			
Crowns	33% coinsurance, Plan pays 67%	33% coinsurance, Plan pays 67%	Covered[3]
Dentures, fixed bridges	Not covered[4]	50% coinsurance, Plan pays 50%	Covered[3]
Implants	Not covered[4]	50% coinsurance, Plan pays 50% (maximum of $500)	Covered[3]
Orthodontia	Not covered[4]	Plan pays a maximum of $1,500 per person per lifetime[5]	Covered[3]

[1] You must use an in-network dentist to receive 100% coverage; 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.

[2] If you are enrolled in the Health Enhancement Program, frequency limits and cost share are applicable; however, periodontal maintenance and periodontal root scaling & planing do not apply to the annual $500 benefit maximum.

[3] Contact Cigna at 800-244-6224 for patient copay amounts.

[4] While these services are not covered, you will get the discounted rate on these services if you visit an in-network dentist, unless prohibited by state law.

[5] Benefits prorated over the course of treatment.

Comparing Your Dental Coverage Options

	Basic Plan	Enhanced Plan	DHMO® Plan
Can I receive services from any dentist?	Yes, but you will pay less when you choose an in-network provider	Yes, but you will pay less when you choose an in-network provider	No, all services must be received from a contracted in-network dentist
Do I need a referral for specialty dental care?	No	No	Yes
Will I pay a flat rate for most services?	No, you will pay a percentage of the cost of most services	No, you will pay a percentage of the cost of most services after you reach your annual deductible	Yes
Must I live in a certain service area to enroll?	No	No	Yes, you must live in the DHMO's service area
Is orthodontia covered?	No	Yes	Yes
Are dentures or bridges covered?	No	Yes	Yes

Coverage for Fillings Under the Basic and Enhanced Plans

The Basic and Enhanced Plans provide coverage for amalgam (silver) fillings. If you decide to get a composite (that is, white) filling, you'll be responsible for paying the dentist the difference between the silver filling covered by the plan and the more expensive composite filling.

Pre-Treatment Estimates

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 800-244-6224 or **www.cigna.com/stateofct**.

Cigna Dental Programs

- **Oral Health Integration Program®.** Enrolled retirees and dependents 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. Qualifying medical conditions for OHIP include heart disease, stroke, diabetes, pregnancy, chronic kidney disease, organ transplants, and head and neck cancer radiation. For additional information about OHIP, visit **www.cigna.com/stateofct**.
- **Healthy Rewards®.** Cigna's Healthy Rewards Program provides discounts of up to 60% on health-related programs and services. There's no time limit or maximum for these instant savings when you visit a participating provider or shop online. No referrals or claim forms are needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins. Learn more about Healthy Rewards at **cigna.com/rewards** (password: savings) or by calling 800-258-3312.

Frequently Asked Questions

General

- **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 copays. For detailed benefit descriptions and information about how to access Plan services, contact the insurance carriers at the phone numbers or websites listed on page 57.

- **Can I enroll later or switch plans mid-year?**

  Generally, the elections you make at Open Enrollment are effective July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 8). If you decline coverage now, you may enroll during any future Open Enrollment or if you have certain qualifying status changes.

Medical Coverage

- **I live outside Connecticut. Do I need to choose an Out-of-Area plan?**

  If you live permanently outside of Connecticut, we will place you automatically 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 for those retired prior to October 2, 2017.

- **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 group of doctors, hospitals and other providers who contract with the insurance carrier to provide discounted fees for their services. In a POE plan, you may use only network providers. In a POS plan, you may use network and non-network providers, but you pay less when you use network providers.

- **What are my options if I want access to doctors anywhere in the U.S.?**

  Both State of Connecticut insurance carriers offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you may choose one of the Out-of-Area plans—both have national networks.

- **How do I find out which networks my doctor is in?**

  Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 57. It's likely your doctor participates in more than one network.

Dental Coverage

- **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 the plan that is best for you, compare the plan-to-plan features in the *Dental Coverage At-a-Glance* table on page 33 and weigh your priorities.

- **How long can my children stay on the dental plan? Can they stay covered through the end of the calendar year they turn age 26, like with the medical plans?**

  The Affordable Care Act extended benefits for children through the end of the calendar year they turn age 26 only under medical and prescription drug coverage, not dental coverage. Dental coverage ends for dependent children at age 19. 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.

- **Do any of the dental plans cover orthodontia for adults?**

  Yes, the Enhanced Plan and DHMO 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.

- **If I participate in HEP, are my regular dental cleanings covered 100%?**

  Yes, up to two cleanings per year. However, if you are in the Enhanced Plan, you must use an in-network dentist to receive 100% 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). If you enroll in the DHMO, you must use a network dentist or your exam and cleaning won't be covered (except in cases of emergency).

Coverage for Individuals Eligible for Medicare

As a Medicare-eligible retiree or dependent, you are eligible for medical, prescription drug and dental coverage under the Connecticut State Retiree Health Plan.

Medicare-eligible coverage is only for Medicare-eligible retirees and their enrolled dependents who are also eligible for Medicare. If you or your dependents are NOT eligible for Medicare, please read *Coverage for Individuals Not Eligible for Medicare*, which begins on page 15.

Medicare and You

Medicare is a federal health care insurance program for people age 65 and older. The age at which you are eligible for Social Security may be higher than age 65, depending on the year in which you were born. While your Social Security retirement age may be higher than age 65, your eligibility for Medicare starts at age 65. People younger than age 65 may also qualify for Medicare due to certain disabilities or health conditions. If you or a dependent becomes eligible for Medicare because of disability, be sure to contact the Retiree Health Insurance Unit at 860-702-3533 no matter your/their age. Medicare enrollment is required for anyone that is eligible.

Medicare Part A and Part B

Medicare coverage has various parts. Medicare Part A (hospital care) is free and enrollment is automatic if you are eligible for Medicare. You must enroll in Medicare Part B (physician services) and pay a monthly 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 at least 3 months before your 65th birthday.** Failing to do so will result in a disruption in your health coverage.

Note: If you are not eligible for free Medicare Part A, you are not required to enroll in Part A. If this is the case, you must submit a statement to the Retiree Health Insurance Unit from the Social Security Administration verifying that you are not eligible for premium-free Medicare Part A. You are still required to enroll in Medicare Part B, even if you are not eligible for Part A.

If you or a dependent were eligible for Medicare at age 65 or earlier due to a disability, but you did not enroll in Medicare Part A and/or Part B, the Social Security Administration may assess a late enrollment penalty for each year in which you were eligible but failed to enroll. You will still be required to enroll in Medicare Part A and B in order to receive coverage through the State of Connecticut Retiree Health Plan, even if you are assessed a penalty.

Once You Enroll in Medicare

As a State of Connecticut Retiree Health Plan member, when you reach age 65, the State will enroll you automatically in the UnitedHealthcare Group Medicare Advantage (PPO) plan. Your State-sponsored medical and prescription coverage through the UnitedHealthcare Group Medicare Advantage (PPO) plan will become your only medical and prescription plan.

Just before your 65th birthday, you will receive a letter from the Retiree Health Insurance Unit with more information about the UnitedHealthcare Group Medicare Advantage (PPO) plan. Be sure to send the Retiree Health Insurance Unit a copy of your red, white and blue Medicare card. Your standard premium for Medicare Part B will be reimbursed by the State starting on the date a copy of your Medicare Part B card is received by the Retiree Health Insurance Unit. Medicare premiums paid before a copy of your card is received will not be reimbursed. For 2019, the standard Medicare Part B/Part D premium reimbursement is $135.50.

You may be required to pay more than the standard premium; or an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Parts B and D in addition to the standard premium. Social Security will advise you by letter annually if you are required to pay a higher rate. IMPORTANT: To receive full reimbursement, send a copy of this letter along with a copy of your red, white and blue Medicare card, to the Retiree Health Insurance Unit.

Note: If you lose eligibility for Medicare, you MUST contact the Retiree Health Unit right away to avoid a disruption in your coverage under the State of Connecticut Retiree Health Plan.

Enrolling in Other Medicare Advantage or Medicare Prescription Drug Plans

The UnitedHealthcare Group Medicare Advantage plan includes prescription drug coverage. When you or your enrolled dependents become eligible for Medicare, you will be enrolled automatically in the UnitedHealthcare Group Medicare Advantage plan. You do not need to do anything except start using your UnitedHealthcare card once you receive it. Once enrolled, you will receive more information. However, there are four key things to know:

1. **The UnitedHealthcare Group Medicare Advantage plan is your only option for State-sponsored medical and prescription drug coverage.** If you "opt out" of the UnitedHealthcare plan, you opt out of your State-sponsored coverage. UnitedHealthcare is required by Medicare to inform you of the chance to opt out or cancel your enrollment. However, if you opt out, medical and prescription drug coverage and Medicare premium reimbursements for you and your dependents will terminate. If you wish to continue State-sponsored health coverage, please ignore the opt-out information.
2. **Do not enroll in a stand-alone Medicare Advantage or Medicare prescription drug plan (Medicare Part C or Part D).** You are only able to enroll in one Medicare Advantage and one Medicare Part D plan at a time. The UnitedHealthcare Group Medicare Advantage plan includes Medicare Part D prescription drug coverage. **Enrolling in any other Medicare Advantage or Medicare Part D plan will disenroll you from the UnitedHealthcare Group Medicare Advantage plan and cause your State-sponsored medical and pharmacy coverage to end for you and your dependents.**
3. **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 Retiree Health Insurance Unit. This is a requirement of the U.S. Centers for Medicare & Medicaid Services. All communication will still go to your noted mailing address.
4. **Promptly submit higher premium notices.** If your premium will be more than the standard premium rate, send a copy of your IRMAA notice to the Retiree Health Insurance Unit to ensure proper reimbursement.

Individuals Who are Not Eligible for Medicare

If you or your covered dependents are not yet eligible for Medicare (typically those under age 65), current medical coverage elections and prescription drug coverage through CVS/Caremark will stay the same. There will be no change to their copay structure, and they will continue to participate in their current drug programs. For more information on non-Medicare-eligible coverage, see page 15.

Medical Coverage

Your medical coverage option is the UnitedHealthcare Group Medicare Advantage (PPO) plan. Medicare Advantage plans (also known as Medicare Part C) combine all of the benefits of Medicare Part A (hospital coverage) and Medicare Part B (medical coverage) into one plan, and can also be combined with Medicare Part D (prescription drug coverage) to become one comprehensive hospital, medical and prescription drug plan. Medicare Advantage plans are offered by private insurance companies like UnitedHealthcare.

Your medical coverage option is a **Group** Medicare Advantage plan, which means it was created just for the Connecticut State Retiree Health Plan. Unlike other Medicare Advantage plans you may see advertised elsewhere, you can only enroll in this plan through the Connecticut State Retiree Health Plan.

How the Plan Works

The UnitedHealthcare Group Medicare Advantage plan is a Preferred Provider Organization (PPO) plan. Here are some highlights of the plan:

- You can see any doctor, hospital or other health care provider you choose, as long as they accept Medicare
- You pay the same amount for care whether you see a network or non-network provider anywhere in the U.S.
- Medicare sees each enrolled member as an individual; you will have your own Medicare ID card and enrollment record
- Your health care bills go to UnitedHealthcare directly, NOT Medicare. Then, your UnitedHealthcare plan pays for your care. This is why it is very important for you to use your UnitedHealthcare plan member ID card when you need health care services.

Please refer to the UnitedHealthcare Group Medicare Advantage (PPO) plan Summary of Benefits or Evidence of Coverage for additional information about the medical plan.

Medical Coverage At-a-Glance

The table below shows the coverage available under the medical plan. As a reminder, the retirement groups are:

- **Group 1:** Retirement date prior to July 1999
- **Group 2:** Retirement date July 1, 1999 – May 1, 2009, and those who retired under the 2009 Retirement Incentive Plan
- **Group 3:** Retirement date June 1, 2009 – October 1, 2011
- **Group 4:** Retirement date October 2, 2011 – October 1, 2017
- **Group 5:** Retirement date October 2, 2017 or later.

Benefit Features	UnitedHealthcare Group Medicare Advantage (PPO) Plan In-Network & Out-of-Network				
	Group 1	Group 2	Group 3	Group 4	Group 5
Annual deductible	None	None	None	None	None
Annual medical out-of-pocket maximum	$2,000	$2,000	$2,000	$2,000	$2,000
Primary Care Physician office visit	$5	$15	$15	$15	$15
Specialist office visit	$5	$15	$15	$15	$15
Preventive services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Emergency care	Plan pays 100%	Plan pays 100%	Plan pays 100%	$35	$100
Diagnostic radiology services (e.g., MRIs, CT scans)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Lab services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient x-rays	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient hospital care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Skilled nursing facility (SNF)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient surgery	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient rehabilitation (physical, occupational or speech/language therapy)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%

continued on next page

Benefit Features	UnitedHealthcare Group Medicare Advantage (PPO) Plan In-Network & Out-of-Network				
	Group 1	Group 2	Group 3	Group 4	Group 5
Therapeutic radiology services (such as radiation treatment for cancer)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Ambulance	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Diabetes monitoring supplies*	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Urgently needed services	$5	$15	$15	$15	$15
Routine physical (one per plan year)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Acupuncture** (up to 20 visits per plan year)	$15	$15	$15	$15	$15
Chiropractic care** (unlimited visits per plan year)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Routine foot care** (six visits per plan year)	$5	$15	$15	$15	$15
Routine hearing exam** (one exam every 12 months)	$15	$15	$15	$15	$15
Hearing aids** (one set within a 36-month period)	Unlimited allowance toward 2 hearing aids	Unlimited allowance toward 2 hearing aids	Unlimited allowance toward 2 hearing aids	Unlimited allowance toward 2 hearing aids	Unlimited allowance toward 2 hearing aids
Routine vision exam** (one exam every 12 months)	$15	$15	$15	$15	$15
Routine naturopathic services (unlimited visits)	$5	$15	$15	$15	$15

** Only select brands are covered: OneTouch® Ultra® 2, OneTouch® UltraMini®, OneTouch® Verio®, OneTouch® Verio® IQ, OneTouch® Verio® Flex™, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Connect*

***Benefits are combined in- and out-of-network.*

UnitedHealthcare Additional Programs

- **Call NurseLine 24/7.** If you have a question about a medication or a health concern, call NurseLine 24/7 at 877-365-7949. A registered Nurse will take your call.
- **Renew Rewards: Complete an annual physical or wellness visit—and earn a reward!** Earn gift cards for completing healthy activities, like an annual physical or wellness visit. Your visit is covered 100% by the Plan—you'll pay a $0 copay. To receive your gift card reward, all you need to do is complete your annual physical or wellness visit between January 1, 2019 and September 30, 2019. Let UnitedHealthcare know you completed your visit by registering online at **www.UHCRetiree.com/CT** or by phone toll-free at 888-803-9217, 8 a.m. – 8 p.m., Monday - Friday. Your visit must be reported by December 31, 2019 to be eligible for a gift card.
- **HouseCalls: Enjoy a clinical visit in the comfort of your own home.** UnitedHealthcare HouseCalls is an annual wellness program offered at no extra cost. The program sends an advanced practice clinician—a nurse practitioner, physician assistant or medical doctor—to your home for up to one hour of one-on-one time. During the visit, the clinician will:
  - Provide a personalized health screening, nutrition and wellness tips, and educational materials;
  - Review your medical history and help you prepare for any upcoming doctors visits; and
  - Assist you with creating personalized health goals or a healthy action plan.

  HouseCalls will then send a summary of your visit to your primary care provider so he/she has this information about your health. Plus, when you complete a HouseCalls visit, you can receive a $15 gift card! (Note: HouseCalls may not be available in all areas.)
- **Solutions for Caregivers: Make caring for a loved one easier.** At no additional cost, Solutions for Caregivers supports you, your family and those you care for by providing information, education, resources and care planning. Also included is an on-site evaluation by a registered nurse and a personal plan of care developed by a geriatric case manager. You will also have access to UHC's Caregiver Partners website so you can explore the UHC library of articles, buy caregiver-related products and services, and share information among family members to help improve communication and decision-making.
- **Virtual Doctor Visits: Chat with a doctor through online video chat—24/7.** Use your computer, tablet or smartphone to speak with a board-certified doctor anytime, anywhere. You can ask questions, get a diagnosis and even get medications sent to your local pharmacy. Virtual doctor visits are covered 100% by the Plan—you'll pay a $0 copay. Speak with a virtual doctor about non-life-threatening health concerns, like allergies, cold/cough, pink eye, rash, fever, flu, sore throats, diarrhea, migraines, stomach aches, and more! To sign up, call UnitedHealthcare Customer Service toll-free at 888-803-9217, 8 a.m. – 8 p.m., Monday – Friday. Get more details at **www.UHCvirtualvisits.com** or **www.UHCRetiree.com/CT**.

UnitedHealthcare Additional Programs *(continued)*

- **Go beyond the plan benefits to help live your best life.** We all want to live a healthier, happier life. Renew by UnitedHealthcare can be your guide. Renew, our member-only Health & Wellness Experience, includes inspiring lifestyle tips, learning activities, videos, recipes, interactive health tools, rewards and more, all designed to help you live your best life. Explore all that Renew has to offer by logging in to **www.UHCRetiree.com/CT**.
- **Get active and have fun with SilverSneakers® Fitness.** Designed for all fitness levels and abilities, SilverSneakers includes access to exercise equipment, classes and more at 13,000+ fitness locations. SilverSneakers signature classes, offered at select locations, are led by certified instructors trained specifically in adult fitness and include a range of options from using light hand weights to more intense circuit training.

Prescription Drug Coverage

UnitedHealthcare contracts with Medicare, provides insurance and pays the claims for your pharmacy benefits. OptumRx is the pharmacy benefit manager for UnitedHealthcare and processes prescription drug claims and conducts administrative work on UnitedHealthcare's behalf. It also administers the mail order prescription drug program. UnitedHealthcare and OptumRx are part of UnitedHealth Group.

The plan has a five-tier copay structure. This means the amount you pay for each prescription drug depends on whether your prescription is for a preferred generic drug, a generic drug, a brand name drug listed on OptumRx's preferred drug list (the formulary), a non-preferred brand name drug or a specialty drug. The amount you pay also depends on where you fill your medication and when you retired, as shown in the following tables.

For questions about your prescription drug coverage, contact UnitedHealthcare using the contact information on page 57.

Prescription Drug Coverage At-a-Glance

	Network Retail & Mail Service Pharmacy				
	Group 1	Group 2	Group 3	Group 4	Group 5
1- to 84-day supply of non-maintenance drugs					
Tier 1: Preferred Generic	$3	$3	$5	$5	$5
Tier 2: Generic	$3	$3	$5	$5	$10
Tier 3: Preferred Brand	$6	$6	$10	$20	$25
Tier 4: Non-Preferred Brand	$6	$6	$25	$35	$40
Tier 5: Specialty	$6	$6	$25	$35	$40
1- to 84-day supply of maintenance drugs[1, 2]					
Tier 1: Preferred Generic	$3	$3	$5	$5/$0[3]	$5/$0[3]
Tier 2: Generic	$3	$3	$5	$5/$0[3]	$10/$0[3]
Tier 3: Preferred Brand	$6	$6	$10	$10/$5[3]	$25/$5[3]
Tier 4: Non-Preferred Brand	$6	$6	$25	$25/$12.50[3]	$40/$12.50[3]
Tier 5: Specialty	$6	$6	$25	$25/$12.50[3]	$40/$12.50[3]
84- to 90-day supply of maintenance drugs[1]					
Tier 1: Preferred Generic	$0	$0	$0	$5/$0[3]	$5/$0[3]
Tier 2: Generic	$0	$0	$0	$5/$0[3]	$10/$0[3]
Tier 3: Preferred Brand	$0	$0	$0	$10/$5[3]	$25/$5[3]
Tier 4: Non-Preferred Brand	$0	$0	$0	$25/$12.50[3]	$40/$12.50[3]
Tier 5: Specialty	$0	$0	$0	$25/$12.50[3]	$40/$12.50[3]

[1] *The State of Connecticut Retiree Health Plan includes additional coverage not covered under Medicare Part D. A list of additional drugs covered as well as a list of maintenance drugs can be found in UnitedHealthcare's Additional Drug Coverage document.*

[2] *Maintenance drugs for Group 4 and Group 5 are covered up to a 90-day supply.*

[3] *Plan includes reduced copays for medications to treat 1) asthma or COPD; 2) diabetes (Type 1 or 2); 3) heart failure/heart disease; 4) hyperlipidemia (high cholesterol); or 5) hypertension (high blood pressure). See UnitedHealthcare's Additional Drug Coverage document for a list of drugs with a reduced copay.*

Prescription Drug Tiers

A drug's tier placement is determined by OptumRx. If new generics have become available, new clinical studies have been released or new brand name drugs have become available, etc., OptumRx may change the tier placement of a drug.

Prior Authorization

Certain prescription drugs require prior authorization. If a drug you are taking requires prior authorization, you must have your prescribing doctor ask for coverage of the drug by calling UnitedHealthcare Customer Service at 888-803-9217 (TTY 711), 9 a.m. to 9 p.m. ET, Monday through Friday. If you continue to fill your prescriptions for the drug without getting prior authorization, the drug will not be covered and you may have to pay the full retail price.

Tips for Reducing Your Prescription Drug Costs

- **Compare and contrast prescription drug costs.** Contact UnitedHealthcare to find the tier of the prescription drugs you and your family members use. If you have any Tier 3 or Tier 4 drugs, consider speaking with your doctor about switching to a generic equivalent.
- **Use the Mail Service Pharmacy.** If you are taking a maintenance medication for a long-term condition, such as asthma, high blood pressure or high cholesterol, switch your prescription from a retail pharmacy to the Mail Service Pharmacy. Once you begin using the Mail Service Pharmacy, you can conveniently order refills by phone or online. Contact UnitedHealthcare for more information.

Dental Coverage

Cigna is the dental carrier for the State of Connecticut's three dental plans:

- **Basic Plan.** This plan allows you to visit any dentist or dental specialist without a referral.
- **Enhanced Plan.** This plan also allows you to visit any dentist or dental specialist without a referral, but pays a different level of benefits than the Basic Plan.
- **Dental HMO Plan (DHMO).** This plan provides dental services only from a defined network of dentists and pays benefits only when you receive care from a network dentist. You must select a Primary Care Dentist. He/she will coordinate your care. Referrals are required for all specialist services.

Many of the Basic and Enhanced Plan network dentists have agreed to offer their discounted fees to you and your enrolled dependents for non-covered services. You must visit network dentists to receive the discounts (savings will not apply for care received from non-participating dentists). Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. 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.

Dental Coverage At-a-Glance

	Basic Plan	Enhanced Plan	DHMO® Plan
Annual deductible	None	Individual: $25; Family: $75 The deductible does not apply to routine exams, cleanings and x-rays	None
Annual benefit maximum	None; $500 per person for periodontics	$3,000 per person; excluding orthodontia	None
Routine exams, cleanings, x-rays	Plan pays 100%	Plan pays 100%[1]	Covered[2]
Periodontal maintenance	20% coinsurance, Plan pays 80% If retired after 10/1/2011: Plan pays 100%	Plan pays 100%[1]	Covered[2]
Periodontal root scaling and planing	50% coinsurance, Plan pays 50%	20% coinsurance, Plan pays 80%	Covered[2]
Other periodontal services	50% coinsurance, Plan pays 50%	20% coinsurance, Plan pays 80%	Covered[2]
Simple restorations			
Fillings	20% coinsurance, Plan pays 80%	20% coinsurance, Plan pays 80%	Covered[2]
Oral surgery	33% coinsurance, Plan pays 67%	20% coinsurance, Plan pays 80%	Covered[2]
Major restorations			
Crowns	33% coinsurance, Plan pays 67%	33% coinsurance, Plan pays 67%	Covered[2]
Dentures, fixed bridges	Not covered[3]	50% coinsurance, Plan pays 50%	Covered[2]
Implants	Not covered[3]	50% coinsurance, Plan pays 50% (maximum of $500)	Covered[2]
Orthodontia	Not covered[3]	Plan pays a maximum of $1,500 per person per lifetime[4]	Covered[2]

[1] *You must use an in-network dentist to receive 100% coverage; 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.*

[2] *Contact Cigna at 800-244-6224 for patient copay amounts.*

[3] *While these services are not covered, you will get the discounted rate on these services if you visit an in-network dentist, unless prohibited by state law.*

[4] *Benefits prorated over the course of treatment.*

Coverage for Fillings Under the Basic and Enhanced Plans

The Basic and Enhanced Plans provide coverage for amalgam (silver) fillings. If you decide to get a composite (that is, white) filling, you'll be responsible for paying the dentist the difference between the silver filling covered by the plan and the more expensive composite filling.

Comparing Your Dental Coverage Options

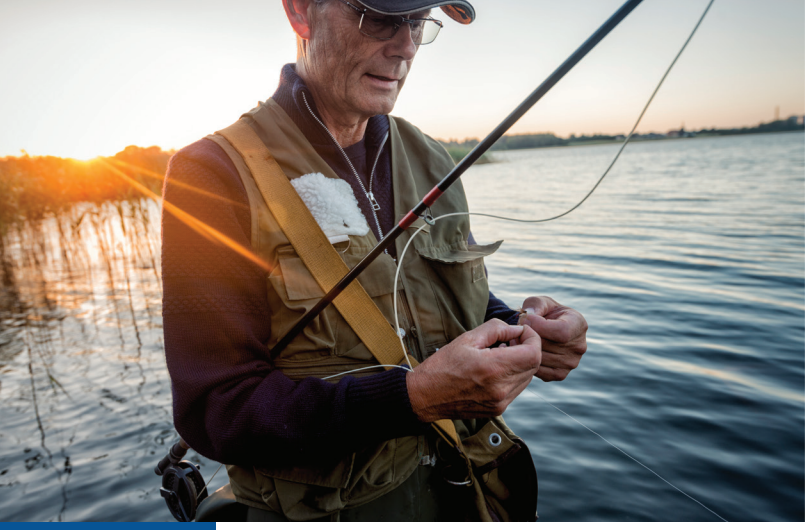
	Basic Plan	Enhanced Plan	DHMO® Plan
Can I receive services from any dentist?	Yes, but you will pay less when you choose an in-network provider	Yes, but you will pay less when you choose an in-network provider	No, all services must be received from a contracted in-network dentist
Do I need a referral for specialty dental care?	No	No	Yes
Will I pay a flat rate for most services?	No, you will pay a percentage of the cost of most services	No, you will pay a percentage of the cost of most services after you reach your annual deductible	Yes
Must I live in a certain service area to enroll?	No	No	Yes, you must live in the DHMO's service area
Is orthodontia covered?	No	Yes	Yes
Are dentures or bridges covered?	No	Yes	Yes

Pre-Treatment Estimates

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 800-244-6224 or www.cigna.com/stateofct.

Cigna Dental Programs

- **Oral Health Integration Program®.** Enrolled retirees and dependents 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. Qualifying medical conditions for OHIP include heart disease, stroke, diabetes, pregnancy, chronic kidney disease, organ transplants, and head and neck cancer radiation. For additional information about OHIP, visit www.cigna.com/stateofct.
- **Healthy Rewards®.** Cigna's Healthy Rewards Program provides discounts of up to 60% on health-related programs and services. There's no time limit or maximum for these instant savings when you visit a participating provider or shop online. No referrals or claim forms are needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins. Learn more about Healthy Rewards at cigna.com/rewards (password: savings) or by calling 800-258-3312.



Frequently Asked Questions

General

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

  For detailed benefit descriptions and information about how to access Plan services, contact UnitedHealthcare at the phone number or website listed on page 57.

- **Do I need to enroll in Medicare?**

  Yes! When individuals turn age 65 or first become eligible for Medicare, they must enroll in Medicare Parts A and B. They must pay or continue to pay their monthly Part B premium. If they stop paying their Part B monthly premium, they risk losing their Connecticut State Retiree Health Plan medical and prescription drug coverage.

- **Do retirees still have Medicare?**

  Yes. With the UnitedHealthcare Group Medicare Advantage plan, retirees will have all the rights and privileges of traditional Medicare. Instead of the federal government administering retirees' Medicare Part A and Part B benefits as it does under traditional Medicare, UnitedHealthcare is the administrator, through the UnitedHealthcare Group Medicare Advantage plan.

- **Are Medicare-eligible retirees and their Medicare-eligible dependents covered under the same policy, like family coverage?**

  No. While the Medicare-eligible retiree and any Medicare-eligible dependents will be enrolled in the same UnitedHealthcare Group Medicare Advantage plan, Medicare considers each person to be a separate member. As a result, each Medicare-eligible plan member will receive his or her own UnitedHealthcare ID card. It also means that each UnitedHealthcare plan member will receive their own set of plan documents.

Medical

- **Is the UnitedHealthcare Group Medicare Advantage (PPO) plan nationwide?**

  Yes, this plan offers nationwide coverage.

- **Do I need to use my red, white and blue Medicare card?**

  No, you should use your UnitedHealthcare Group Medicare Advantage ID card for all covered medical and prescription drug needs. Put your Original Medicare card somewhere for safekeeping. It is important that you use your UnitedHealthcare ID card each time you receive medical services or fill a prescription.

- **How are claims processed?**

  UnitedHealthcare pays all claims directly. By always showing your UnitedHealthcare ID card, you ensure your claims are processed correctly, in a timely way and accurately.

- **Is the UnitedHealthcare Group Medicare Advantage (PPO) plan a Medicare Advantage HMO plan with a limited network?**

  No. It is a national plan that allows you to see doctors and hospitals anywhere in the United States. You are not limited to seeing providers only in Connecticut. The plan travels with you throughout the United States. The service area is all counties in all 50 U.S. states, the District of Columbia and all U.S. territories.

- **What happens if I travel outside the U.S. and need medical coverage?**

  You will have worldwide coverage for emergency and urgently needed care. You may need to pay the entire claim when receiving care and then submit the claim to UnitedHealthcare for reimbursement after returning to the U.S.

Dental

- **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 *Dental Coverage At-a-Glanc*e table on page 50 and weigh your priorities.

- **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 8). If you decline coverage now, you may enroll during any later Open Enrollment or if you experience certain qualifying status changes.

- **How long can my children stay on the dental plan? Can they stay covered through the end of the calendar year they turn age 26, like with the medical plans?**

  The Affordable Care Act extended benefits for children through the end of the calendar year they turn age 26 only under medical and prescription drug coverage, not dental. Dental coverage ends for dependent children at age 19. 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.

- **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.

Do NOT complete the application on the next page if you want to keep your current coverage without any changes. Your coverage will continue automatically.

RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744-OE REV. 4/2018

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 Retiree Health Insurance Unit.

You must submit a completed enrollment application and any required documentation to the Retiree Health Insurance Unit **within 30 days** of your initial benefits eligibility date or **within 30 days** of a qualified change in family status. Please refer to your annual Health Care Options Planner for more information.

① Your Personal Information

Retiree/Survivor Last Name	**First Name, MI**	**Retirement Date**	**Employee Number** (From Active Employment)

Street Address (no P.O. boxes)	**City**	**State**	**Zip Code**

Social Security Number	**Date of Birth** (MM/DD/YYYY)	**Gender** (M/F)	**Home Telephone Number**

Email Address	**Cell/Mobile Telephone Number**

② Application Type

- ☐ New Retirement Enrollment
- ☐ Annual Open Enrollment
- ☐ Adding/Dropping Dependents

Qualifying Status Change:

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Change in Dependent Eligibility Status

Date of Event: ____/ ____/ _____

- ☐ Start of Other Coverage
- ☐ Loss of Other Coverage
- ☐ Death of Spouse/Dependent

③ Your Medicare Information

Complete this section if you are eligible for Medicare and would like to enroll in State-sponsored medical and prescription coverage. If you are not yet eligible for Medicare, leave this section blank.

Medicare Claim Number (as it appears on your card)	**Medicare Part A Effective Date** (MM/DD/YYYY)	**Medicare Part B Effective Date** (MM/DD/YYYY)	**End Stage Renal Diagnosis** ☐ **Yes** ☐ **No**

④ Choose Non-Medicare Medical Plan

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.

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

⑤ Choose Your Dental Plan

☐ Basic Dental Plan ☐ Enhanced PPO Dental Plan ☐ Dental HMO Plan ☐ Waive Dental Coverage

⑥ Spouse/Dependent Information

List all of your dependents to be enrolled or dropped 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 Retiree Health Insurance Unit.

Name	Relationship	Gender	Date of Birth	Social Security Number	Medical		Dental	
					Add	Drop	Add	Drop
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

⑦ Dependent Medicare Information

List all Medicare eligible dependents. Attach additional sheet if necessary. If no dependents are eligible for Medicare, leave this section blank.

Name	**Medicare Claim Number** (as it appears on Medicare card)	**Medicare Part A Effective Date** (MM/DD/YYYY)	**Medicare Part B Effective Date** (MM/DD/YYYY)	**End Stage Renal Diagnosis** ☐ **Yes** ☐ **No**

⑧ Signature & Authorization

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 may be 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 me or my eligible dependent(s). It is my responsibility to notify the Office of the State Comptroller when a dependent becomes ineligible. 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/Survivor Signature	**Date**

Contact Information

Coverage	Provider	Phone	Website
Questions about: eligibility, enrollment, coverage changes and premiums	Office of the State Comptroller Retiree Health Insurance Unit	860-702-3533	www.osc.ct.gov
Coverage for Non-Medicare-Eligible Individuals			
Medical	Anthem BlueCross BlueShield • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-State • Anthem State BlueCare (POS)	800-922-2232	www.anthem.com/statect
	UnitedHealthcare (Oxford) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford Out-of-Area	800-385-9055 Call 800-760-4566 for questions before you enroll	www.welcometouhc.com/stateofct
Prescription Drug	CVS/Caremark	800-318-2572	www.caremark.com
Health Enhancement Program (HEP)	WellSpark Health	877-687-1448	www.cthep.com
Dental	Cigna • Basic Plan • Enhanced Plan • DHMO Plan	800-244-6224	cigna.com/StateofCT
Coverage for Medicare-Eligible Individuals			
Medical & Prescription Drug	UnitedHealthcare • Group Medicare Advantage (PPO) plan	888-803-9217 TTY 711 9 a.m. - 9 p.m. ET, Monday – Friday Behavioral Health: 800-453-8440	www.UHCRetiree.com/CT
Dental	Cigna • Basic Plan • Enhanced Plan • DHMO Plan	800-244-6224	cigna.com/StateofCT

Glossary

- **Brand name drug.** FDA-approved prescription drugs marketed under a specific brand name by the manufacturer. The FDA is the U.S. Food and Drug Administration.
- **Coinsurance.** The percentage of the cost you pay when you receive certain eligible health care services. Generally, you start paying coinsurance after you meet your annual deductible (see deductible, below).
- **Copay.** The flat-dollar amount you pay when you receive certain covered health care services (or when you fill a drug prescription). Generally, you start paying copays after you meet your annual deductible (see deductible, below).
- **Deductible.** The amount you pay for covered medical services each plan year before the Plan pays benefits. Once you've met the deductible, you share the cost of covered medical services with the Plan through coinsurance or copays.
- **Dependent.** A family member who meets the eligibility criteria established by the State of Connecticut Retiree Health Plan for Plan enrollment.
- **Dental Health Maintenance Organization (DHMO).** Entity that provides dental services through a limited network of providers. DHMO plan participants only obtain services from network dentists and need a referral from a primary care dentist before seeing a specialist.
- **Effective date.** The calendar year your health care coverage begins. You are not covered until your effective date.
- **Premium contribution.** The amount you must pay on a monthly basis toward the cost of health care. This is withdrawn automatically from your monthly pension check.
- **Formulary.** A comprehensive list of prescription drugs that are covered by a prescription drug plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective. Formularies are updated periodically.

- **Generic drug.** The FDA-approved therapeutic equivalent to a brand name prescription drug containing the same active ingredients and costing less than the brand name drug.
- **Health Maintenance Organization (HMO).** An entity that provides health services through a closed network of providers. Unlike PPOs, HMOs employ their own staff or contract with specific groups of providers. HMO participants typically need a referral from a primary care provider before seeing a specialist.
- **In-network.** Providers or facilities that contract with a health plan to provide services at pre-negotiated fees. You usually pay less when using an in-network provider.
- **Open Enrollment.** A period of time when you can change your health benefit elections without a qualifying status change.
- **Out-of-area.** A location outside the geographic area covered by a health plan's network of providers.
- **Out-of-network.** Providers or facilities that are not in your health plan's provider network. Some plans do not cover out-of-network services. Others charge a higher coinsurance when you receive out-of-network care.
- **Out-of-pocket costs.** The amount you pay—including premiums, copays and deductibles—for your health care.
- **Out-of-pocket maximum.** The most you'll pay out-of-pocket each plan year. When you meet the out-of-pocket maximum, the Plan will pay 100% of covered expenses for the rest of the plan year.
- **Preferred Provider Organization (PPO).** A network of providers that provide in-network services to plan enrollees at negotiated rates but allows enrollees to receive covered services from out-of-network providers, though often at a higher cost.
- **Primary Care Physician (PCP).** Doctor (or nurse practitioner) who coordinates all your medical care. HMOs require all plan participants to select a PCP.
- **Qualifying status change.** A life event that allows you to make a change in your benefit elections outside of Open Enrollment, as defined by the IRS. Qualifying changes include marriage, separation, divorce, birth or adoption of a child, death of a dependent, and obtaining or losing other health coverage.
- **Reasonable and customary (R&C).** The average fee charged by a particular type of health care practitioner within a geographic area. R&C is often used by medical plans as the most they will pay for a specific test or procedure. If the fees are higher than the approved amount and care is received from a non-network provider, the individual receiving the service is responsible for paying the difference.
- **Specialty drug.** Generally, high-cost drugs used to treat long-term or chronic conditions.

10 Things Retirees Should Know

1. **The Connecticut State Retiree Health Plan is your trusted resource for health benefits information.** If you have questions about your benefits contact the Retiree Health Insurance Unit at 860-702-3533 or visit the Comptroller's website at **www.osc.ct.gov**.
2. **Retiree health benefits structure is determined by the State.** Eligibility for retiree health benefits is determined by your retirement date and your eligibility for Medicare.
3. **If you're enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) plan, you do not need to use your red, white and blue Medicare card.** You should use your UnitedHealthcare Group Medicare Advantage ID card for all covered medical and prescription drug needs. Put your Original Medicare card somewhere for safekeeping. It is important that you use your UnitedHealthcare ID card each time you receive medical services or fill a prescription.
4. **Retirees and dependents may be enrolled in different plans, depending on Medicare-eligibility.** All State Health Plan members who are eligible for Medicare are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) plan. State Health Plan retirees and dependents who are not eligible for Medicare can choose from a variety of plan options, which do not include the UnitedHealthcare Group Medicare Advantage plan. This means that some retirees and dependents may be enrolled in different plans. This is often referred to as a "split family."
5. **Retirees and dependents must enroll in Medicare Part A and Part B as soon as they're eligible.** Retirees and dependents who are Medicare-eligible based on age or disability must enroll in premium-free Medicare Part A hospital insurance and Medicare Part B medical insurance.

6. **Do not enroll in a stand-alone Medicare Part D prescription drug plan.** The UnitedHealthcare Group Medicare Advantage (PPO) plan includes Medicare prescription drug coverage. If you enroll in a stand-alone Medicare Part D (Medicare prescription drug) plan, you may be disenrolled from this Plan.
7. **Medicare-eligible members must pay premiums to the federal government.** Your standard premium for Medicare Part B is reimbursed by the State starting with the date your Medicare Part B card is received by the Retiree Health Insurance Unit.
8. **Premiums for coverage must be paid, if applicable.** Premiums you must pay for non-Medicare-eligible health coverage or dental coverage will be deducted automatically from your monthly pension check. If your pension check is not enough to cover the premium amount, you must pay the balance to continue eligibility for coverage.
9. **You must disenroll ineligible dependents within 31 days after the date they become ineligible.** Find more information on qualifying status changes on page 8. If you continue to cover an ineligible dependent after the 31-day period, you may be charged a fine.
10. **If you change your home address, contact the Office of the State Comptroller.** If you move, make sure to notify the Office of the State Comptroller about your change of address so we can keep you informed about your benefits.

Non-Discrimination Notice

Discrimination is Against the Law

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.

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- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
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  - 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
www.hhs.gov/ocr/office/file/index.html.

Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-860-702-3340.
繁體中文 (Chinese)	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 。
Tiếng Việt (Vietnamese)	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.
Tagalog (Tagalog – Filipino)	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.
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-860-702-3340.
Kreyòl Ayisyen (French Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-860-702-3340.
Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-860-702-3340.
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-860-702-3340.
Português (Portuguese)	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-860-702-3340.
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-860-702-3340.
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-860-702-3340.
हिंदी (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-860-702-3340 पर कॉल करें।
اُردُو (Urdu)	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-860-702-3340.
Shqip (Albanian)	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-860-702-3340.
λληνικά (Greek)	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-860-702-3340.

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