A Message from the State Comptroller

Your choices make a difference. Every day you make decisions about your health and your healthcare – you walk instead of drive, you have the salad instead of the fries, you get regular checkups and dental care.

What you do every day affects your health and what you pay out of pocket for your healthcare. Even if you’re happy with your current coverage, it’s a good idea to review the plans each year. All of the medical plans cover the same services – the differences are in which providers are in each network, how you access care, and how each plan helps you manage your family’s health.

You may be able to change your plan, keep seeing the same doctors, and reduce your payroll deduction for health insurance.

Please note the negotiated changes to your pharmacy benefits on page 14 and to your payroll deduction amounts for each plan on page 20.

Take a few minutes now to consider your options and choose the best value for you and your family. Everyone wins when you make smart choices about your health and your healthcare.

Nancy Wyman  
State Comptroller  
May 2009
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Current Employees

Open Enrollment Is May 18 – June 5

Every spring during open enrollment, you have the opportunity to adjust your healthcare benefit choices. It’s a good time to take a fresh look at the plans, consider how your and your family’s needs may have changed, and choose the best value. For 2009 Open Enrollment information, please go to the Comptroller’s website at http://www.osc.state.ct.us or check with your personnel office.

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

If you’d like to make a change for 2009-2010, contact your agency personnel or payroll office to request a Benefit Enrollment Form.

If you don’t want to make changes, you don’t need to do a thing, your current coverage will continue automatically at the new rates listed on page 20.

New Employees

Action Required: Enroll Within 30 Days

To enroll for the first time, follow these steps:

1. Review this booklet and choose the medical and dental options that best meet your needs
2. Complete an enrollment form (available from Human Resources)
3. Return the form within 30 calendar days of the date you were hired.

If you enroll as a newly hired employee, your coverage begins the first day of the second month of your employment. For example, if you’re hired on October 15th, your coverage begins December 1.

The elections you make now are effective through June 30, 2010 unless you have a qualifying status change.
### Your Medical Coverage at a Glance

<table>
<thead>
<tr>
<th>BENEFIT FEATURES</th>
<th>ALL CARRIERS</th>
<th>ALL CARRIERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>POE AND POE-G</td>
<td>POS IN NETWORK</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each Individual</td>
<td>None</td>
<td>$300</td>
</tr>
<tr>
<td>Family (3 or more)</td>
<td>None</td>
<td>$900</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximums</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each Individual</td>
<td>None</td>
<td>$2,000 (plus deductible)</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$4,000 (plus deductible)</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>None</td>
<td>You pay 20% of allowable charge plus*</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Outpatient Physician Visits</strong></td>
<td>$10 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>No copayment for well-child visits and immunizations</td>
<td>80%</td>
</tr>
<tr>
<td>Adults**</td>
<td>$5 copay</td>
<td></td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Contraceptives- Rx plan</td>
<td>Covered on same basis as other prescription drugs</td>
<td>Covered on same basis as other prescription drugs</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>100% (pre-certification required)</td>
<td>80% (pre-certification required)</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>100% (pre-certification required)</td>
<td>80% (pre-certification required)</td>
</tr>
<tr>
<td><strong>Inpatient Physician</strong></td>
<td>100% (pre-certification required)</td>
<td>80% (pre-certification required)</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>100% (pre-certification required)</td>
<td>80% (pre-certification required)</td>
</tr>
<tr>
<td><strong>Outpatient Surgical Facility</strong></td>
<td>100% (pre-certification required)</td>
<td>80% (pre-certification required)</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>100% (if emergency)</td>
<td>100% (if emergency)</td>
</tr>
<tr>
<td><strong>Pre-admission Certification/ Concurrent Review</strong></td>
<td>Through participating provider</td>
<td>Penalty of 20% up to $500 for no certification</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Pre-certification required</td>
<td>Pre-certification required</td>
</tr>
<tr>
<td>Inpatient</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$10 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td>Pre-certification required</td>
<td>Pre-certification required</td>
</tr>
<tr>
<td>Detoxification</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$10 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>100% (pre-certification required)</td>
<td>80%, up to 60 days/year (pre-certification required)</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>100% (pre-certification required)</td>
<td>80%, up to 200 visits/year (pre-certification required)</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>100% (pre-certification required)</td>
<td>80%, up to 60 days (pre-certification required)</td>
</tr>
<tr>
<td><strong>Short Term Rehabilitation and Physical Therapy</strong></td>
<td>100%</td>
<td>80%, up to 60 inpatient days, 30 outpatient days per condition per year</td>
</tr>
<tr>
<td><strong>Diagnostic X-Ray and Lab</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Pre-Admission Testing</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Urgent or Emergency Care</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>100% (pre-certification required)</td>
<td>80% (pre-certification required)</td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td>100% (pre-certification required)</td>
<td>80% (pre-certification required)</td>
</tr>
<tr>
<td><strong>Routine Eye Exam</strong></td>
<td>$15 copay, 1 exam per year</td>
<td>50%, 1 exam every 2 years</td>
</tr>
<tr>
<td><strong>Audiological Screening</strong></td>
<td>$15 copay, 1 exam per year</td>
<td>80%, 1 exam per year</td>
</tr>
</tbody>
</table>

This is a brief summary of covered expenses. (See Your Benefit Resources on page 23 to receive more detailed information.)

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

**Note:** For adult physical examinations and routine gynecological examinations and Pap smears pursuant to carrier plan schedules.
What’s New for 2009-2010

1. **Anthem State Preferred POS Plan closed to new enrollment** – employees currently enrolled in the Preferred Plan can continue but no new enrollments will be allowed.

2. **Prescription drug plan changes** – see page 14.

3. **Lower adult preventive care copay** – see page 3.

4. **Negotiated increase in employee contributions** – see page 20.

5. **New rules for dependents age 19 – 26.** Dependents between the ages of 19 and 26 may be enrolled in the plan if they reside within the State of Connecticut, or they are full-time students and reside outside the State of Connecticut. Contact your agency payroll/benefits staff for details.

Making Your Decision

Each of the medical plans offered by the State of Connecticut is designed to cover the same expenses – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. (The main difference is that you’ll pay a $10 copay for outpatient visits under the POE plans and a $15 copay for outpatient visits under the other plans.) **Yet, the amount deducted from your paycheck varies quite a bit from plan to plan.** How do you decide?

When it comes to choosing a medical plan, there are four main areas to look at:

1. **What is covered** – the services and supplies that are covered expenses under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 3.)

2. **Cost** – what you pay when you receive medical care and what is deducted from your paycheck. What you pay at the time you receive services is similar across the plans (see the chart on page 3). However, payroll deductions vary quite a bit (see page 20).

3. **Networks** – whether your doctor or hospital have contracted with the plan. (See pages 5 and 6.)

4. **Plan features** – how you access care and what kinds of “extras” the plan offers. Under some plans you must use network providers except in emergencies, others give you access to out-of-network providers. Finally, you may prefer one company over another (see pages 7-13).

The following pages are designed to help you compare your options.
When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you’re like many people, you made a choice when you were first hired and haven’t really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs. Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your providers and receiving the same healthcare services?

Many doctors belong to multiple provider networks. And, over the last few years, all of the plans have made significant improvements to their provider networks. Now is the time to check to see if your provider is a network provider under more than one of the plan options. Then, take a fresh look at your options. You may be able to save money every pay period without changing doctors.

Why Networks Matter

All of the plans cover the same healthcare services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Each plan contracts with a group of doctors and hospitals for discounted rates on healthcare services. Getting your care within the network provides the highest benefit level:

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

Is a National Network Important to You?

All State of Connecticut plans have a national provider network. That means they contract with doctors and hospitals across the country – and you have nationwide access to the highest level of benefits.

- Thinking of retirement and planning to travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that’s not in Connecticut or in the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. All plans have a national network available. Check to see if you might have access to doctors and hospitals across the country even when you choose a POE or POE-G plan. And, if you choose a POS plan, you have nationwide options for care at in-network benefit levels. Take a look at your options before you decide.
How the Plans Work

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

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

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

Using Out-of-Network Providers

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

In the POS plans there are no referral or precertification requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require precertification (see page 3), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You’ll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live or Work Affects Your Choices

You must live or work within a plan’s regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the Health Net Charter Plan, you must live or work within the Health Net regional provider network. If you live and work outside that area, you should choose one of the out-of-area plans. Both plans give you access to a national provider network.
Comparing Plan Features

All State of Connecticut plans cover the same healthcare services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency), some give you access to out-of-network providers when you pay more of the fees, some require you to select a PCP.

- **Health promotion** – Remember, there’s more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.

- **Provider networks** – You’ll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 23 for phone numbers and websites.)

- **Discounts** – All plans offer discounts to members for certain health-related expenses such as gym memberships and eyeglasses.

### About Value-Added Programs

Another area where the plans may differ is the value-added programs they offer. These programs are outside the contracted plan benefits — they’re “extras” that each company offers in hopes of making their plan stand out, such as:

- Member discounts (for example, on weight-loss programs or health clubs)
- Wellness programs
- Online health promotion programs

Because these value-added programs are not plan benefits, they are subject to change at any time by the health plan. However, you may want to see what each plan offers before you decide.

### Comparing Plan Features Table

<table>
<thead>
<tr>
<th></th>
<th>POINT OF ENROLLMENT – GATEKEEPER (POE-G) PLANS</th>
<th>POINT OF ENROLLMENT (POE) PLANS</th>
<th>POINT OF SERVICE (POS) PLANS</th>
<th>OUT OF AREA PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National network</td>
<td>National network</td>
<td>National network</td>
<td>National network</td>
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<tr>
<td></td>
<td>Regional network</td>
<td>Regional network</td>
<td>Regional network</td>
<td>Regional network</td>
</tr>
<tr>
<td></td>
<td>In- and out-of-network coverage available</td>
<td>In- and out-of-network coverage</td>
<td>In- and out-of-network</td>
<td>In- and out-of-network</td>
</tr>
<tr>
<td></td>
<td>In-network coverage only (except in emergencies)</td>
<td>In-network coverage only</td>
<td>In-network coverage only</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td></td>
<td>No referrals required for care from in-network providers</td>
<td>No referrals required for care from in-network providers</td>
<td>No referrals required for care from in-network providers</td>
<td>No referrals required for care from in-network providers</td>
</tr>
<tr>
<td></td>
<td>Primary care physician (PCP) coordinates all care</td>
<td>Primary care physician (PCP) coordinates all care</td>
<td>Primary care physician (PCP) coordinates all care</td>
<td>Primary care physician (PCP) coordinates all care</td>
</tr>
</tbody>
</table>

* Closed to enrollment.
Comparing Plans: A Message From Anthem

Anthem Blue Cross and Blue Shield Offerings

<table>
<thead>
<tr>
<th>State BlueCare POE Plus</th>
<th>State BlueCare POS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Benefits</strong></td>
<td><strong>In/Out-of-Network Benefits</strong></td>
</tr>
<tr>
<td>• $10 office visit copay</td>
<td>• $15 office visit copay</td>
</tr>
<tr>
<td>• Referral needed to see a specialist</td>
<td>• Annual physical and routine eye exams, immunizations, flu shots, gynecological exams, pap tests, mammograms, colorectal screenings and routine blood work</td>
</tr>
<tr>
<td>• Annual physical and routine eye exams, immunizations, flu shots, gynecological exams, pap tests, mammograms, colorectal screenings and routine blood work</td>
<td>• Over 17,000 Connecticut and 751,000 national providers are in the network</td>
</tr>
<tr>
<td>• Over 17,000 Connecticut and 751,000 national providers are in the network</td>
<td>• An extensive local and national hospital network</td>
</tr>
<tr>
<td>• An extensive local and national hospital network</td>
<td>• Quest – the largest laboratory network in Connecticut – is in the network</td>
</tr>
<tr>
<td>• Quest – the largest laboratory network in Connecticut – is in the network</td>
<td>• National access</td>
</tr>
<tr>
<td>• National access</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>State BlueCare POE</th>
<th>Anthem Out-of-Area Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Benefits</strong></td>
<td><strong>In-Network Benefits</strong></td>
</tr>
<tr>
<td>• $10 office visit copay</td>
<td>• $15 office visit copay</td>
</tr>
<tr>
<td>• Annual physical and routine eye exams, immunizations, flu shots, gynecological exams, pap tests, mammograms, colorectal screenings and routine blood work</td>
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</tr>
<tr>
<td>• Over 17,000 Connecticut and 751,000 national providers are in the network</td>
<td>• Over 19,000 Connecticut and 738,000 national providers are in the network</td>
</tr>
<tr>
<td>• An extensive local and national hospital network</td>
<td>• An extensive local and national hospital network</td>
</tr>
<tr>
<td>• Quest – the largest laboratory network in Connecticut – is in the network</td>
<td>• Quest – the largest laboratory network in Connecticut – is in the network</td>
</tr>
<tr>
<td>• National access</td>
<td>• National and international network</td>
</tr>
</tbody>
</table>

Happy Birthday to me!

A great way to remember to get your routine physical and screenings each year is to schedule them during your birthday month. Just think of it as giving yourself the gift of health.

Finding a Primary Care Physician (PCP)

State BlueCare POS, State BlueCare POE and State BlueCare POE Plus feature national and international access. State of Connecticut employees and retirees who reside in Connecticut, Massachusetts or Rhode Island can enroll in any State BlueCare plan and select a Primary Care Physician.

To find a provider, call 1-800-810-BLUE (2583) or visit our website at anthem.com/statect > find a doctor > search national BlueCard directory > next > enter prefix identification > next > enter address or select by county > next > select a provider type > view results.
You can also access a Guest Membership through our Away From Home Care coverage.

**Helping you stay healthy is our priority with local, dedicated service**

For more than 55 years, we’ve been proud to serve State of Connecticut employees, retirees and their families with the kind of local, dedicated service you deserve. We’re here to help you get the most out of your health benefits and wellness programs so that you can stay on top of your health.

- Local, State-dedicated Member Services Unit full of knowledgeable, caring people
- Local, onsite dedicated retiree specialist
- State-dedicated website to find a doctor, check claims, order ID cards and more

**Vision**

**Eye Exams**

Your State of Connecticut health benefits cover you for an annual routine eye exam. No matter which plan you have, you do not need a referral.

**Value-Added Discounts**

- **EyeMed** – Save up to 30% on eyeglasses, 25% on nonprescription sunglasses and enjoy discounted prices on exams. Choose from private practitioners or leading optical retailers including LensCrafters®, Target® Optical, Sears Optical, JC Penney Optical and most Pearle Vision® locations.
- **TruVision™** - Pay just $895 to $1,895 per eye on LASIK laser vision correction or receive discounts of 15-20% and free shipping on contact lens orders.

**LCA Vision**

Save 15% on LASIK with all in-network providers and prices as low as $695 per eye with “select” providers. The Premier Lasik Network is one of the largest surgeon networks in the U.S. with more than 550 locations.

**SpecialOffers@AnthemSM**

As a State employee or retiree, you can access discounts on all kinds of healthy living products and services by visiting anthem.com/statect > SpecialOffers@Anthem. These are just a few of the discounts available:

- **Weight loss programs** – Weight Watchers®, Jenny Craig®, Lindora Online™, LivingLean
- **Fitness club memberships, fitness equipment, coaching**
- **Hearing aids**
- **Allergy products**
- **Acupuncture**
- **Massage therapy**
- **Barnes and Noble**
- **Baby products and supplies**
- **Senior Care products and services**

**360° Health®**

With our 360° Health® program, you get the information and services you need to live a healthier life and feel your best every day.

- **Health Resources** – Get info on wellness, health topics and specific conditions 24/7 online or through our Audio Tape Library and NurseLine
- **Health Extras** – Use interactive tools to learn more about staying healthy. Get discounts on healthy living products and services, including a smoking cessation program
- **Health Guidance** – Get support and guidance when you need it, 24/7, including the Future Moms maternity care program and Behavioral Health Advisors
- **Health Management** – Learn how to best manage a chronic illness or condition with Condition Care programs and the Neonatal Intensive Care Unit program

For more information, call our State-dedicated Member Services Unit at 1-800-922-2232 or visit our website at anthem.com/statect.
For over ten years, Health Net has insured State of Connecticut employees and retirees. Being a Connecticut company ourselves, we are proud to be offered as an option to State of Connecticut employees. As a state employee, you are given the opportunity each spring to choose your health coverage for you and your family. This year, we encourage you to take another look at your options; a lot can change in a year.

Here are some of the many reasons why Health Net is more than “just another plan” and A Better Decision …

- **Strong Regional Network** – Our Tri-State Advantage Platinum network includes every hospital in Connecticut, and over 160,000 provider office locations and 244 hospitals in New York, New Jersey and Connecticut.

We have also added some new best-in class providers this year that State of Connecticut members have requested including:

- **Fairfield County Medical Group** – New this year to the Health Net Advantage Platinum Network is one of the most requested medical practices in the State of Connecticut. Located in Trumbull, Fairfield County Medical Group is open five days a week with physicians who practice primary care, endocrinology and Rheumatology.

- **National Network** – at no additional cost to you! We offer quality physicians, facilities, and hospitals that give you excellent choice and access across all 50 states. (See the next page for details)

- **Decision Power** – brings together under one roof the information, resources and personal support that fits you, your health and your life. Whether you’re focused on staying fit, dealing with back pain or facing a serious diagnosis, we’re here to help you work with your doctor and make informed decisions.

- **Health Risk Questionaire (HRQ):** Through our partnership with WebMD® Health Net members have the ability to complete a confidential Health Risk Questionnaire (HRQ). This assessment will lead you through a series of questions that in the end will help you identify potential health risks and will suggest ways for you to improve and control them.

The HRQ is a member’s gateway to ongoing recommendations and resources based on your unique health profile and goals. In just minutes, you’ll get an instant health picture and more ways to take control of your health.

- **Health Coaches** are specially trained healthcare professionals such as nurses, dietitians and respiratory therapists who provide unbiased, evidence-based health information and coaching. They are available 24 hours a day, 7 days a week, to help members understand their treatment options and provide useful information and decision making support.

Decision Power Health Coaches also help members address chronic conditions day and night such as including asthma, diabetes, heart failure, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease, other conditions including back pain, osteoarthritis, uterine fibroids and prostate and uterine cancers.

1. As of January 2009
• **Complex Care Support:** Members with care needs that require an intensive level of service are referred to the Complex Case Management (CCM) Program. The CCM Program’s collaborative approach facilitates communication among patients, their families, treating physicians, and other providers of care. The goal is to support the treating physician’s care plan and complement case management.

• **Wellness Programs** – Members can become more active participants in making healthy decisions with programs addressing smoking cessation, weight management, fitness, nutrition, stress management, cholesterol management, blood pressure management, and healthy pregnancy.

• **Quality Care Initiatives** – to help ensure the care you receive is safe and effective.

• **National Committee for Quality Assurance** (NCQA) rating of “Excellent” for Health Net of Connecticut, New York and New Jersey-U.S.²

• **U.S. News & World Report** recognized Health Net as one of the top commercial health plans in the country³

…And if you look closer, you may find the difference between “just another health plan” and a partner who supports you and your family on your path to optimal wellness.

We understand these things. It’s what sets us apart. Our mission is to help people be healthy, secure and comfortable. We provide services that help individuals and families when they need them most, in ways that matter.


### National Network Access for State of Connecticut Members Enrolled with Health Net

State of Connecticut health plan members enrolled with Health Net can access in-network level benefits nationwide when seeking care outside of the service area. This national network is available for all Health Net plans offered to State of Connecticut employees and retirees.

To find participating physicians or hospitals, visit the customized web site for State of Connecticut employees and retirees at www.healthnet.com/stateofct or, you may call the telephone number on the back of your Health Net ID card.

### What are the benefits of a national network?

- No additional costs - same in-network copayments you pay today⁴
- No claim forms - simply present your Health Net ID card to any participating First Health provider (members are required to obtain prior authorization for specified services)
- No pre-registration necessary to obtain covered services from physicians outside our service area

### Who benefits most from a national network⁵?

- Retirees who may reside elsewhere part of the year
- Students attending college outside of our service area
- Professors or teachers on sabbatical
- Those who travel for business

For more information, please call the State of Connecticut dedicated Member-Services Line at 1-800-255-5019 or visit www.healthnet.com/stateofct.

2. Accredited July 5, 2006 and valid until July 5, 2009
4. For full coverage to apply, plan requirements regarding medical necessity and prior authorizations must be met. See your Evidence of Coverage (EOC) for additional details and requirements. Members must obtain Prior Authorization when required.
5. State of Connecticut Members who permanently reside and work outside of Health Net’s service area are not eligible for this program offering.
Comparing Plans:
A Message From UnitedHealthcare®

Here’s Why You Should Select an Oxford® plan from UnitedHealthcare

With the lowest cost POS option (United Healthcare Oxford Freedom Select) and a national seamless network in all State of Connecticut plans, it’s no wonder United-Healthcare, featuring State of Connecticut Oxford plans, is the fastest growing carrier choice for State of Connecticut employees. Every Oxford product plan provides access to our national network of 583,000 physicians and healthcare professionals1 and our regional network in Connecticut, New York and New Jersey of over 79,000 providers2. We provide access to over 220 hospitals nationwide – including all 33 hospitals in Connecticut.

Over the years we have been the only carrier to offer this kind of access to State of Connecticut employees, while keeping your cost shares low. Plus, State of Connecticut Retirees can enjoy the same access to quality care with our seamless nationwide network, so they can live and travel around the country without worry.

Three Steps to Quality, Affordable Health Coverage

1) Select an Oxford plan to meet your budget and your coverage needs
   • We offer coverage options and plan designs that work for your personal and medical circumstances, at very affordable rates.
   • Oxford plans are among the lowest cost options of all plans offered to State of Connecticut employees.

2) Visit the Web site to search for a doctor
   • Log in to www.oxfordhealth.com/stateofct, a customized State of Connecticut Employee Web site, and follow the directions to “Search for a Doctor”. To find doctors outside of New York, New Jersey or Connecticut, visit www.myuhc.com and click on the Find Physician or Facility link. Click on the “Search for a Physician” button. Be sure to choose “UnitedHealthcare Choice Plus” from the “Select a Plan” drop-down options.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.
• Members can also **search** for doctors identified under our **Premium® designation program** who meet or exceed evidenced-based performance standards for quality of care and cost-efficiency criteria. This user-friendly tool gives members access to information sorted by physician quality and cost-efficiency, enabling them to make informed decisions about where to get their care.

3) **Sign up now for access to our health discount programs!** Our health discount programs complement your medical plan by offering savings on a wide range of health and wellness products and services for you and your family. From vision, dental and hearing care to health supplies and long-term care services, members get preferred rates.

• **Vision care savings** from a nation-wide network of eye care professionals and facilities, as well as convenient online programs. Discount vision care savings include:
  
  – 20% savings on eyeglass frames, lenses and options like tinting
  – 10% to 20% savings on professional fees for contact lens fittings;
  – LASIK and other vision correction surgeries at a 15% discount, plus more!

• **Healthy Bonus® and Health Allies** programs provide discounts and special offers **to help you to stay healthy while saving money** on weight loss programs, fitness products, nutrition products and publications, and more. All materials about these member discount programs, as well as other useful resources can be found by visiting [www.oxfordhealth.com/stateofct](http://www.oxfordhealth.com/stateofct).

When you select an Oxford plan from UnitedHealthcare you get a better value with more choices.

**State of Connecticut Benefits Contact Information**

<table>
<thead>
<tr>
<th>Medical Coverage</th>
<th>Member Services (pre-enrollment)</th>
<th>1-800-760-4566</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member Services (post-enrollment)</td>
<td>1-800-385-9055</td>
</tr>
</tbody>
</table>

www.oxfordhealth.com/stateofct

**Dental Coverage**

Dedicated Service Center

1-800-896-4834

www.myuhcdental.com/statect

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2 As of December 31, 2008, this data represents all participating providers except ancillary providers (i.e., laboratories, radiology centers, urgent care centers, etc.) and hospitals. Dental and complementary and alternative medicine providers are included. Providers who are board certified in more than one specialty are counted for each specialty. Therefore, providers who are board certified in more than one specialty are counted multiple times.

3 Offers are valid through December 31, 2009. Healthy Bonus and Health Allies offers are not insured benefits and are in addition to, and separate from, Oxford benefit coverage. These arrangements have been made for the benefit of members and do not represent an endorsement or guarantee on the part of the Oxford plan. Offers may change from time to time and without notice and are applicable to the items referenced only. Offers are subject to the terms and conditions imposed by the vendor. Oxford cannot assume any responsibility for the products or services provided by vendors or the failure of vendors referenced to make available discounts negotiated with Oxford. However any failure to receive offers should be reported to Customer Service by calling the number on your Oxford member ID card.
Changes Effective July 1, 2009

Effective July 1, there are significant changes to the prescription drug program, including a 3-tier copay structure.

The following language is from the recently negotiated SEBAC agreement:

- The Parties agree to implement a Three Tier Prescription Drug Formulary effective July 1, 2009 for active employees covered by the Plan. This Formulary shall be applicable to employees who retire on or after July 1, 2009 except such employees who retire under the 2009 Retirement Incentive Program as described in this Agreement. Current retirees shall continue to be covered by the existing prescription drug benefit plan.

- The Healthcare Cost Containment Committee shall have overall responsibility for the participation of the parties in the implementation of the plan.

- The employee co-payments for the 3 Tier Formulary shall be $5 for a generic drug; $10 for a preferred brand name drug; and $25 for a non-preferred brand name drug. A non-preferred brand name drug will be available with a $10 copay based upon medical necessity as certified by the member’s physician in accordance with the Pharmacy Benefit Manager’s (PBM) process.

- The prescription benefit plans will have mandatory generic substitution except that a physician may authorize an override based upon medical necessity certified by the physician in accordance with the PBM’s process.

- There shall be a transition period commencing July 1, 2009 during which employees shall receive communication materials explaining the new Formulary program. The transition period shall be ninety days measured from July 1, 2009 during which time patients who were taking non-preferred brand name drugs for an ongoing medical condition beginning before July 1, 2009 shall pay the $10 preferred brand name drug copay.

Watch for Details from Caremark

You will receive a mailing from Caremark with details about the new prescription drug program. In addition, if any of your current prescriptions will fall in the new third tier, Caremark will notify you so there are no surprises. Please carefully review the information you receive from Caremark.
Before starting extensive dental procedures for which the dentist’s charges may exceed $350, you can ask your dentist to submit a pre-treatment estimate to the Plan. You can also help to determine the amount you will be required to pay for a specific procedure by using the Plan’s website.

More details about covered expenses are available by contacting the plans by phone. (See Your Benefit Resources on page 23.)

### Terms to Know

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

**Enhanced Dental PPO** – This plan offers dental services both within and outside a defined network of dentists and dental specialists without a referral.

**DHMO Plan** – This plan provides dental services only from a defined network of dentists. You must select a primary care dentist (PCD) to coordinate all care and referrals are required for all specialist services.

---

<table>
<thead>
<tr>
<th></th>
<th>UNITED BASIC (any dentist)</th>
<th>UNITED ENHANCED (network)</th>
<th>CIGNA DHMO® (network only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>$25 individual, $75/family</td>
<td>None</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>None ($500 per person for periodontics)</td>
<td>$3,000 per person (excluding orthodontics)</td>
<td>None</td>
</tr>
<tr>
<td><strong>Exams and X-rays</strong></td>
<td>Covered at 80%</td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td><strong>Simple Restoration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>Covered at 80%</td>
<td>Covered at 100%</td>
<td>Covered*</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Covered at 67%</td>
<td>Covered at 67%</td>
<td>Covered*</td>
</tr>
<tr>
<td><strong>Major Restoration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns</td>
<td>Covered at 67%</td>
<td>Covered at 67%</td>
<td>Covered*</td>
</tr>
<tr>
<td>Dentures, Fixed Bridges</td>
<td>Not covered</td>
<td>Covered at 50%</td>
<td>Covered*</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td>Not covered</td>
<td>Plan pays $1,500 per person per lifetime</td>
<td>Covered*</td>
</tr>
</tbody>
</table>

* Contact CIGNA at 1-800-244-6224 for patient copay amounts.
Comparing Your Plans:  
A Message From UnitedHealthcare Dental

UnitedHealthcare Dental offers two dental plans to State of Connecticut employees, retirees and their families. Maintaining good oral health is important to overall well being.

The Basic Plan covers most dental services and you can use any dentist or dental specialist. There is no annual deductible or calendar year maximum. Preventive care services are covered at 80%. This plan does not include coverage for sealants, orthodontia, dentures or fixed bridges.

The Enhanced Plan offers comprehensive dental care through a network of participating dentists (at a slightly lower premium). By choosing a network dentist, you maximize your value and enjoy cost savings. Unlike the Basic Plan, the Enhanced Plan includes coverage for sealants, orthodontia, dentures and fixed bridges. You may receive care outside the network, but your out-of-pocket costs will be higher.

See Your Dental Plan Choices at a Glance on page 16 and your payroll deductions on page 21 to compare your options.

Dental Value Programs Available

- For the Enhanced Dental plan only, UnitedHealthCare Dental offers the Consumer MaxMultiplier Rewards program. With the Consumer MaxMultiplier, UnitedHealthcare Dental awards you for getting preventive and diagnostic dental care. Your awards are funds for your dental care that accumulate, can be carried over each year, and are there when you need them.

If you have preventive and diagnostic care during the year, but don’t use up your annual benefit maximum, you will receive a portion of the unused annual benefit. For example, the Enhanced calendar maximum is $3,000 and you use only $1,250 in benefits during the calendar year, your award amount is $700. (Awards are not dollars in an account; they may be used only according to Consumer MaxMultiplier program rules.) Additionally, you are awarded $100 if you receive all your care from a participating network dentist. Awards are calculated for the following year. You can use your awards for both network and out-of-network claims. However, you cannot use your awards for orthodontic services. Claims are submitted as any claim would be for dental services. Your awards will automatically fund any claims for dental services once you exceed your benefit period maximum and up to the amount you have in your award balance. (The maximum balance you can accumulate for this example would be $5,250.)

For information about Consumer MaxMultiplier, visit www.myuhcdental.com/statect and click on “Enrollment/ Benefit Material.”
Comparing the Basic and Enhanced Plans
As you compare the Basic Plan and the Enhanced Dental PPO, it may be helpful to look at some examples of how the plans pay certain dental treatments differently.

<table>
<thead>
<tr>
<th>Example 1:</th>
<th>Basic Plan</th>
<th>Enhanced Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowns</td>
<td>The plan pays 67% of the billed charges in your area. Crowns are limited to 1 time per tooth per 60 consecutive months.</td>
<td>After you’ve met your annual deductible of $25 ($75 per family), the plan pays 67% of the discounted fee negotiated with network providers or maximum allowable charge for non-network providers. Crowns are limited to 1 time per tooth per 60 consecutive months. The plan will pay up to $3,000 per person per calendar year for eligible expenses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 2:</th>
<th>Basic Plan</th>
<th>Enhanced Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Bridges</td>
<td>Not covered</td>
<td>After you’ve met your annual deductible of $25 ($75 per family), the plan pays 50% of the discounted fee negotiated with network providers or maximum allowable charge for non-network providers. Bridges are limited to 1 time per tooth per 60 consecutive months. If it would be equally effective, the plan may pay benefits based on the cost of a partial denture (you would be responsible for the difference). The plan will pay up to $3,000 per person per calendar year for eligible expenses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 3:</th>
<th>Basic Plan</th>
<th>Enhanced Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia</td>
<td>Not covered</td>
<td>The plan pays 50% of the discounted fee negotiated with network providers or maximum allowable charge for non-network providers, up to a lifetime maximum per person of $1,500.</td>
</tr>
</tbody>
</table>

For further details, go to:
www.yourdentalplan.com/enrollment, click on Enrollment Materials, and follow the link to the Basic and Enhanced Dental Plan summaries.

If you anticipate certain dental expenses, you may want to check out the Treatment Cost Estimator at www.myuhcdental.com/statect. With a procedure code from your dentist, you can find out how the plan would pay those expenses – and, what your estimated out-of-pocket cost would be. Choose Plan Information on the left side of the screen then click on Treatment Cost Estimator. You’ll need to log in with your UHC password to use this tool.

Information about benefits, covered services or finding a dentist can be found by calling customer service at 1-800-896-4834 or visiting our website www.myuhcdental.com/statect.

Your UnitedHealthcare Dental plan is underwritten by UnitedHealthcare Insurance Company.
Comparing Your Plans: A Message From CIGNA

CIGNA Dental Care® (DHMO1)
The DHMO plan2 makes it easy and affordable to take care of your dental health.

Q: What are the main features of the CIGNA DHMO plan?
A: You don’t have to worry about annual dollar maximums. There are no deductibles. You’ll have no claim forms to file. You will select a DHMO network general dentist3 to manage all your dental health care needs and he/she will refer you to visit any network specialist.3 You don’t need a referral to visit a network orthodontist or to take children under 7 to a network pediatric dentist.3 Orthodontic coverage is available for children and adults on the DHMO plan.

Q: How do I choose a dentist when I sign up for the plan? Can I change my network dentist later on?
A: When you enroll in the DHMO plan, you are required to select and visit a network general dentist (provider) for all your dental care needs. You can find a network dentist online at www.CIGNA.com before you sign up or go to your personalized website at www.myCIGNA.com after you sign up. You can change your network dentist at any time; changes go into effect the following month. Remember, if you visit a non-network dentist, your treatment may not be covered at all1.

If you’d rather speak to someone, call Customer Service at 1.800.CIGNA24 (1.800.244.6224) and we will help you find a network dentist in your area. Or you can follow the phone prompts to use our automated Dental Office Locator. The automated system will speak the names of the dentists in your area or fax a list of dentists to you.

Q: If I’m new to the CIGNA DHMO plan, can I keep my current dentist?
A: That depends. If your current dentist participates in the CIGNA DHMO network, you can choose him/her as your network general dentist. You can look online at www.CIGNA.com before you enroll to find out, or ask your dental office directly. Sometimes, CIGNA’s online Dental Office Directory may show that your dental office is not accepting new patients even when your office says they are. If this happens, please contact Customer Service at 1.800.CIGNA24 (1.800.244.6224) for assistance.

1 The term “DHMO” is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.
2 The CIGNA DHMO is not available in the following states: AK, HI, ME, MT, NV, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY. Out-of-network benefits are not available with the CIGNA DHMO plan.
3 CIGNA DHMO members must obtain a referral from their network general dentists in order to receive care from network specialists. Referrals are not required for network Pediatric or Orthodontic dentists.
Q: Are braces covered?

A: Your Patient Charge Schedule includes orthodontic benefits. Please refer to your plan documents in your enrollment kit for specifics. If you or your family member started treatment before you joined the CIGNA DHMO plan, please call CIGNA Customer Service to determine if a plan contribution is available.

If you still have questions after reviewing your enrollment information: Visit us on-line at www.cigna.com, or call Customer Service at 1-800-CIGNA24 (1-800-244-6224).

Once you are enrolled in a CIGNA Dental plan:

Our secure, easy-to-use web site, myCIGNA.com, gives you the tools to:

• **Review** your dental plan information.
• **Order** a dental ID card.
• **View** the status of dental claims.
• **Find** and change network dentist offices.
• **Get** dental health news and information from trusted sources that will help you make informed dental decisions, and much more.

• **Estimate** your out-of-pocket costs and compare the financial impact if you visit an in-network vs. an out-of-network dentist.
• **Save** through **Healthy Rewards®**, CIGNA Dental members get access to a range of health and wellness programs and services often not covered by many traditional benefits plans. **NO REFERRALS. NO CLAIM FORMS. NO CATCH.** For information on available programs and participating providers, simply call 1-800-870-3470 or visit myCIGNA.com.

Some Healthy Rewards programs are not available in all states. If your CIGNA HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your medical benefits. A discount program is NOT insurance, and the member must pay the entire discounted charge.
Your 2009-2010 Payroll Deductions

Bi-Weekly Payroll Deductions – 26 Pay Periods
July 1, 2009 through June 2010

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

<table>
<thead>
<tr>
<th>MEDICAL PLANS</th>
<th>EMPLOYEE</th>
<th>EMPLOYEE +1</th>
<th>FAMILY</th>
<th>FLES¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point of Enrollment - Gatekeeper Plans (POE-G)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthem State BlueCare POE Plus</td>
<td>$19.94</td>
<td>$58.11</td>
<td>$74.87</td>
<td>$38.73</td>
</tr>
<tr>
<td>Health Net Passport HMO</td>
<td>$18.89</td>
<td>$55.52</td>
<td>$71.31</td>
<td>$37.26</td>
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<tr>
<td>UnitedHealthcare Oxford HMO</td>
<td>$17.74</td>
<td>$48.53</td>
<td>$61.69</td>
<td>$33.31</td>
</tr>
<tr>
<td><strong>Point of Enrollment Plans (POE)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthem State BlueCare</td>
<td>$22.25</td>
<td>$67.28</td>
<td>$89.70</td>
<td>$44.87</td>
</tr>
<tr>
<td>Health Net Charter HMO</td>
<td>$21.20</td>
<td>$63.40</td>
<td>$84.20</td>
<td>$42.60</td>
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<tr>
<td>UnitedHealthcare Oxford HMO</td>
<td>$20.04</td>
<td>$59.15</td>
<td>$78.18</td>
<td>$40.12</td>
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<tr>
<td><strong>Point of Service Plans (POS)</strong></td>
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<tr>
<td>Anthem State BlueCare</td>
<td>$28.79</td>
<td>$99.87</td>
<td>$115.44</td>
<td>$51.74</td>
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<tr>
<td>Anthem State Preferred POS</td>
<td>$68.74</td>
<td>$200.78</td>
<td>$235.92</td>
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<tr>
<td>Health Net Charter</td>
<td>$28.08</td>
<td>$95.83</td>
<td>$110.67</td>
<td>$49.95</td>
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<tr>
<td>UnitedHealthcare Oxford HMO</td>
<td>$26.70</td>
<td>$88.05</td>
<td>$101.49</td>
<td>$46.50</td>
</tr>
<tr>
<td>Freedom Select</td>
<td>$26.70</td>
<td>$88.05</td>
<td>$101.49</td>
<td>$46.50</td>
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<tr>
<td><strong>Out of Area Plans (OOA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthem OOA</td>
<td>$28.79</td>
<td>$99.87</td>
<td>$115.44</td>
<td>$51.74</td>
</tr>
<tr>
<td>UnitedHealthcare Oxford USA</td>
<td>$26.70</td>
<td>$88.05</td>
<td>$101.49</td>
<td>$46.50</td>
</tr>
</tbody>
</table>

| DENTAL PLANS                      |        |            |        |      |
| UnitedHealthcare Basic            | $0.00   | $10.62      | $10.62 | $5.44 |
| UnitedHealthcare Enhanced         | $0.00   | $9.77       | $9.77  | $5.00 |
| Cigna DHMO®                       | $0.00   | $3.84       | $5.44  | $2.24 |

¹ The Family Less Employed Spouse (FLES) rate is available only when both spouses are employed by the State of Connecticut, eligible for health insurance, and enrolled in the same plan, along with at least one child.

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

- $5 each pay period saves you ........................................... $130 per year
- $10 each pay period saves you ........................................... $260 per year
- $50 each pay period saves you ......................................... $1,300 per year
- $75 each pay period saves you ......................................... $1,950 per year
- $110 each pay period saves you ........................................ $2,860 per year
Frequently Asked Questions

Where can I get more details about what the plans cover?
You can get more information directly from the plans at the phone numbers or websites listed on page 23.

If I live outside Connecticut, do I need to choose an Out-of-Area Plan?
No, as long as you work in Connecticut, you do not need to choose an Out-of-Area plan.

What are my options if I want access to doctors across the U.S.?
All State of Connecticut plans offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans’ regional service areas, you may choose one of the Out-of-Area plans – both have national networks.

Contact each plan to find out if your provider is in the network that applies to the plan you’re considering. You can search online at the plan’s website (be sure to select the right network; most carriers have more than one), or you can call customer service at the numbers on page 23. It’s likely your provider is covered by more than one network.

Can I enroll later or switch plans mid-year?
Generally, the elections you make now are in effect July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 2). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

Can I enroll myself in one option and my family member in another?
No. You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental coverage. For example, you can enroll yourself and your child for medical but yourself only for dental. To enroll an eligible family member in a plan, you must enroll as well.

I am a 65-year-old active state employee; which health plan card should I present to a doctor’s office or hospital?
When visiting a doctor or hospital, present your State of Connecticut employee plan health card (not your Medicare card). Since you are still working, your employer coverage is your primary health insurance provider; Medicare is secondary.
My spouse is covered under my State medical plan and will soon be eligible for Medicare. Should he sign up for Medicare? What else does he need to do?

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

Because your spouse has coverage through the State plan, there is no need to take action right away. He can sign up for Medicare parts A and B during a later Medicare enrollment period with no penalty while still covered under the State plan or for a limited time after dropping or otherwise losing State coverage. Members should not enroll in Medicare Part D.

For information on Medicare, visit www.medicare.gov.
Your Benefit Resources

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthem Blue Cross and Blue Shield</strong>&lt;br&gt;• Anthem State Preferred POS&lt;br&gt;• Anthem State BlueCare (POS)&lt;br&gt;• Anthem State BlueCare (POE)&lt;br&gt;• Anthem State BlueCare POE Plus&lt;br&gt;• Anthem Out of Area</td>
<td>Anthem.com/stateect</td>
<td>1-800-922-2232</td>
</tr>
<tr>
<td><strong>Health Net</strong>&lt;br&gt;• Health Net Charter (POS)&lt;br&gt;• Health Net Charter HMO&lt;br&gt;• Health Net Passport HMO</td>
<td>Healthnet.com/stateofct</td>
<td>1-800-255-5019</td>
</tr>
<tr>
<td><strong>UnitedHealthcare (Medical)</strong>&lt;br&gt;• Oxford Freedom Select&lt;br&gt;• Oxford HMO Select (POE)&lt;br&gt;• Oxford HMO&lt;br&gt;• Oxford USA Out of Area</td>
<td>Oxfordhealth.com/stateofct</td>
<td>1-800-385-9055&lt;br&gt;Call 1-800-760-4566 for questions before you enroll</td>
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<tr>
<td><strong>Caremark</strong>&lt;br&gt;Prescription drug benefits, any medical plan</td>
<td>Caremark.com/members/stateofct</td>
<td>1-800-318-2572</td>
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<td><strong>UnitedHealthcare (Dental)</strong>&lt;br&gt;• Basic Plan&lt;br&gt;• Enhanced PPO</td>
<td>Myuhcdental.com/stateect</td>
<td>1-800-896-4834</td>
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<td><strong>CIGNA</strong>&lt;br&gt;• DHMO Plan</td>
<td>Cigna.com</td>
<td>1-800-244-6224</td>
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