For State of Connecticut

Employees

HEALTHCARE OPTIONS PLANNER

2011-2012

A Message from State Comptroller Kevin Lembo

How you live your life every day affects your health and what you pay out of pocket for your healthcare. Even if you're happy with your current coverage, it's a good idea to review the plans each year during open enrollment.

All of the State of Connecticut medical plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your family's health. If you decide to change your healthcare plan now, you may be able to keep seeing the same doctors yet reduce your cost for healthcare services.

In addition, during this open enrollment you need to decide if you want to participate in the Health Enhancement Program for 2011-2012.

If you do not enroll by September 15, 2011, you will not be allowed to participate in the Program until the next open enrollment.

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

Kevin Lembo
State Comptroller
August 2011

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What You Need to Do

Current Employees

Open Enrollment Is Now Through September 15, 2011

During this open enrollment you need to decide if you want to participate in the Health Enhancement Program for 2011-2012.

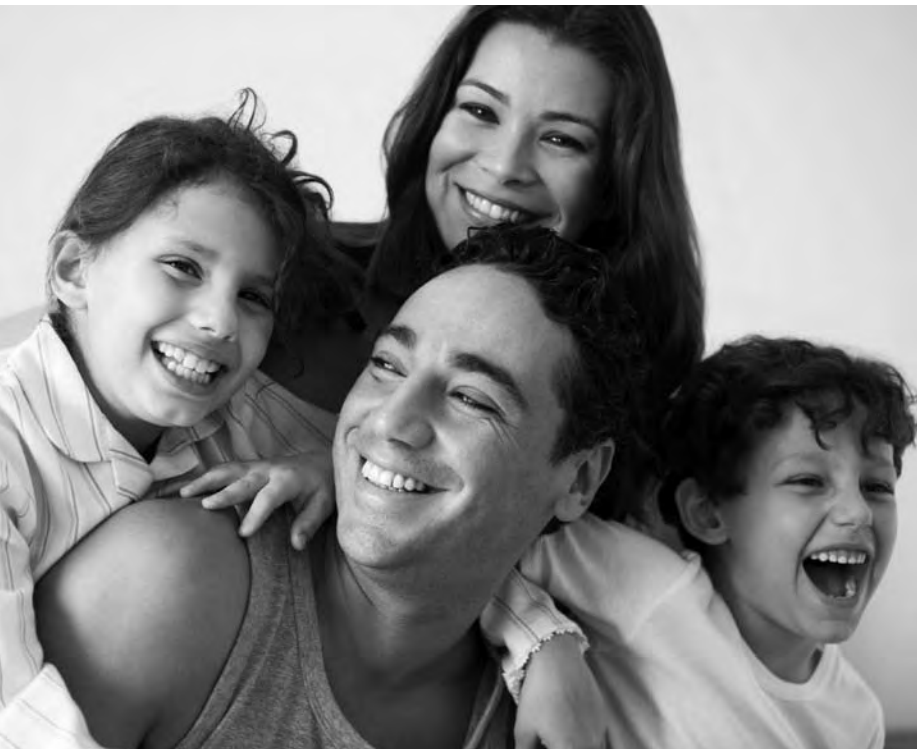
If you do not enroll by September 15, 2011, you will not be allowed to participate in the Program until the next open enrollment.

The annual open enrollment period generally held in May was delayed this year due to the SEBAC discussions. Open enrollment this year runs through September 15, 2011. Now is your 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 plan option for you. For 2011 Open Enrollment information, please go to the Comptroller's website at www.osc.ct.gov 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 if you previously waived coverage.

During this open enrollment you need to decide if you want to participate in the Health Enhancement Program for 2011-2012.

If you'd like to make a change for 2011-2012, contact your agency personnel or payroll office to request a Benefit Enrollment Form.



New Employees

To enroll for the first time, follow these steps:

1. Review this booklet and choose the medical and dental options that best meet your needs.
2. Complete the enrollment form (available from Human Resources).
3. Return the form within 31 calendar days of the date you were hired.

If you enroll as a newly hired employee, your coverage begins the first day of the month following your hire date. For example, if you're hired on October 15, your coverage begins November 1.

The elections you make now are effective through June 30, 2012 unless you have a qualifying status change.

Who's Eligible

It's important to understand who you can cover under the plan. It's critical that the State is providing coverage only for those who are eligible under the rules of the plan.

Eligible dependents are:

- Your legally married spouse or civil union partner
- Your children, including stepchildren, adopted children or children placed with you for adoption, up to age 26 for medical and age 19 for dental
- Minor children for whom you are legal guardian up to age 18.

Disabled children may be covered beyond age 26, with proper documentation from the medical insurance carrier.

Documentation of an eligible relationship is required when you enroll a family member. It is your responsibility to notify your Agency Human Resources Office when any dependent is no longer eligible for coverage.

Make Sure You Cover Only Eligible Dependents

As your children get older or your family situation changes, be sure you consider whether the people you have covered under the plan are still eligible. It can be a costly oversight if you continue to cover an ineligible person.

Did you get divorced or end your civil union? Your ex-spouse/partner is no longer eligible. If you have been ordered to provide healthcare coverage for your ex-spouse, you can do so under COBRA – they cannot remain on this plan. Your stepchildren's coverage will also end.

Are you no longer a legal guardian? In the case of guardianship, the child is no longer eligible when your legal custody ends or the child reaches 18.

Did your child reach age 19? Once your child is 19, they are no longer eligible for dental benefits (unless disabled).

Did your child reach age 26? Once your child is 26, they are no longer eligible for medical and pharmacy benefits (unless disabled).

If you are covering someone who is not an eligible dependent, you will have to pay penalties including federal and state income tax on the fair market value of benefits provided to that individual. You may also face additional penalties.

Choose Carefully

Once you choose your medical and dental plans, you cannot make changes October 1 – June 30 unless you experience a qualifying status change. If you do have a qualifying status change, you must notify Human Resources within 31 days of the event. The change you make must be consistent with your change in status – for example, if you get divorced, you must drop your ex-spouse from coverage.

Please call Human Resources if you experience a qualifying status change – which include changes in:

- **Legal marital/civil union status** – Any event that changes your legal marital/civil union status, including marriage, civil union, divorce, death of a spouse and legal separation.
- **Number of dependents** – Any event that changes your number of dependents, including birth, death, adoption and legal guardianship.
- **Employment status** – Any event that changes your, or your dependent's, employment status, resulting in gaining or losing eligibility for coverage such as:
  - Beginning or ending employment
  - Starting or returning from an unpaid leave of absence
  - Changing from part time to full time or vice versa.
- **Dependent status** – Any event that causes your dependent to become eligible or ineligible for coverage.
- **Residence** – A significant change in your place of residence that affects your ability to access network providers.

If you experience a change in your life that affects your benefits, contact Human Resources. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).

This planner provides a brief summary of covered expenses. See Your Benefit Resources on page 18 to receive more detailed information.

Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS		BOTH CARRIERS
	POE, POE-G AND OUT-OF-AREA IN NETWORK	POS IN NETWORK	POS OUT-OF-NETWORK
Annual Deductible			
Each Individual	$350*		$300
Family (3 or more)	$350* each member ($1,400 maximum)		$900
Annual Out-of-Pocket Maximums			
Each Individual	$350*		$2,000 (plus deductible)
Family	$350* each member ($1,400 maximum)		$4,000 (plus deductible)
Coinsurance	None		You pay 20% of allowable charge plus**
Lifetime Maximum	None		None
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$10 co-pay	$15 co-pay	80%
Preventive Care	No co-payment for preventive care visits and immunizations		80%
Family Planning			
Oral Contraceptives - Rx plan	Covered on same basis as other prescription drugs		Covered on same basis as other prescription drugs
Vasectomy	100% (pre-certification required)		80% (pre-certification required)
Tubal Ligation	100% (pre-certification required)		80% (pre-certification required)
Inpatient Physician	100% (pre-certification required)		80% (pre-certification required)
Inpatient Hospital	100% (pre-certification required)		80% (pre-certification required)
Outpatient Surgical Facility	100% (pre-certification required)		80% (pre-certification required)
Ambulance	100% (if emergency)		100% (if emergency)
Pre-admission Certification/ Concurrent Review	Through participating provider		Penalty of 20% up to $500 for no certification
Mental Health	Pre-certification required		Pre-certification required
Inpatient	100%		80%
Outpatient	$10 co-pay	$15 co-pay	80%
Substance Abuse	Pre-certification required		Pre-certification required
Detoxification	100%		80%
Inpatient	100%		80%
Outpatient	$10 co-pay	$15 co-pay	80%
Skilled Nursing Facility	100% (pre-certification required)		80%, up to 60 days/year (pre-certification required)
Home Health Care	100% (pre-certification required)		80%, up to 200 visits/year (pre-certification required)
Hospice	100% (pre-certification required)		80%, up to 60 days (pre-certification required)
Short Term Rehabilitation and Physical Therapy	100%		80%, up to 60 inpatient days, 30 outpatient days per condition per year
Diagnostic X-Ray and Lab	100% (pre-certification required for diagnostic imaging)		80% (pre-certification required for diagnostic imaging)
Pre-Admission Testing	100%		80%
Emergency Care	100% (co-pay may apply)		100% (co-pay may apply)
Durable Medical Equipment	100% (pre-certification required)		80% (pre-certification required)
Prosthetics	100% (pre-certification required)		80% (pre-certification required)
Routine Eye Exam	$15 co-pay, 1 exam per year		50%, 1 exam every 2 years
Audiological Screening	$15 co-pay, 1 exam per year		80%, 1 exam per year

* Waived for Active Employees and post-October 2011 Retirees enrolled in Health Enhancement Program.

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

What's New for 2011-2012

New Health Enhancement Program

Effective October 1, 2011, the state will implement the voluntary Health Enhancement Program (Program). The Program has several important benefits. First, it will help you and your family work with the medical providers that you choose from the existing state provider network to get and stay healthy. Second, it will save you money on your healthcare. Third, it will save money for the state by focusing our healthcare dollars on prevention. It's your choice whether or not to participate, but there are many advantages to doing so.

The new Health Enhancement Program encourages employees and enrolled family members to take charge of their health and healthcare by following health guidelines defined by the Program.

You Save Money by Participating!

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

If You Do Not Enroll in the Health Enhancement Program

Unless you enroll in the Health Enhancement Program, your premiums will be $100 per month higher and you will have an annual $350 per individual ($1,400 per family) in-network medical deductible. If you do not enroll by September 15, 2011, you will not be allowed to participate in the Program until the next open enrollment. Go to www.cthep.com to enroll.

For employees enrolled in FLES: to participate in the Health Enhancement Program, both employees must enroll.

How to Enroll in the Health Enhancement Program

Enrollment is accessible online at www.cthep.com. On-site enrollment will be available at the 2011 Open Enrollment fairs. Check with your agency Payroll/Human Resources office for fair schedules. If you do not have access to the internet and if you are not able to make it to an Open Enrollment fair you may complete an enrollment form manually. Forms are available at your agency Payroll/Human Resources office or by visiting the Office of the State Comptroller website, www.osc.ct.gov.

Requirements for Everyone Enrolled in the Health Enhancement Program

When you enroll in the Health Enhancement Program, you and your enrolled family members will need to get age-appropriate wellness exams and immunizations, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams).

Those enrolled in the dental plan must also get annual dental cleanings. All of the plans cover up to two cleanings per year. Annual dental cleanings and unlimited periodontal care are included in the Health Enhancement Program.

When you enroll online, you will have a chance to review the requirements and decide whether you want to commit to them.

Additional Requirements for Those With Certain Conditions

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

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

Additional Benefit Plan Changes

The following changes affect your healthcare benefits whether or not you participate in the Health Enhancement Program:

100% Coverage for Recommended Preventive Care

In-network well child visits and immunizations are already covered by the plan with no co-pay. As a result of the Affordable Care Act, preventive care for adults is now 100% covered with no co-pay as well, when you use in-network providers. This applies to all preventive services covered under the Affordable Care Act. For a list, visit www.healthcare.gov/law/about/provisions/services/lists.html.

Pre-Certification Requirement

Making sure you get the right care – not too little and not too much – is one of the ways we can make the best use of our healthcare dollars. Pre-certification is required before you have a diagnostic imaging procedure such as an MRI, CT, CAT, or PET scan. If you use an in-network provider, your provider will take care of this for you. If you use an out-of-network provider, you are responsible for getting pre-certification.

Emergency Room

Effective October 1, 2011, you will pay a $35 co-pay for emergency room visits, unless you are admitted to the hospital from the emergency room or there was no reasonable medical alternative. Co-pays for use of urgent care and walk-in clinics will be the same as your plan's office visit co-pay.

Prescription Drug Changes

If you or your family takes a maintenance medication, you will be able to get your first fill of that medication at any participating pharmacy. After that your two choices are:

- Receive your medication through the Caremark mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the state's new Maintenance Drug Network (all CVS pharmacies will participate and other participating pharmacies will be announced on the Comptroller's website at www.osc.ct.gov when available).

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

PRESCRIPTION DRUG CO-PAYS ARE AS FOLLOWS EFFECTIVE OCTOBER 1, 2011:

For...	Maintenance Drugs 90-Day Supply	Non-Maintenance Drugs 30-Day Supply
Tier 1: Generic drug	$5	$5
Tier 2: Preferred brand-name drug	$10	$20
Tier 3: Non-preferred brand-name drug	$25 ($10 if your physician certifies the non-preferred brand-name drug is medically necessary)	$35 ($20 if your physician certifies the non-preferred brand-name drug is medically necessary)

For those enrolled in the Health Enhancement Program, medications used to treat chronic conditions covered by the Program's disease education and counseling programs cost even less:

- $0 co-pay for Tier 1 (generic)
- $5 co-pay for Tier 2 (preferred)
- $12.50 co-pay for Tier 3 (non-preferred).

There is zero co-pay for medications used to treat diabetes (Type 1 and Type 2).

New Healthy Behavior Programs

Voluntary programs for weight management and tobacco cessation are also being offered. Watch for more information coming soon about these programs.

Making Your Decision

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your payroll deduction varies quite a bit from plan to plan. How do you decide?

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

1. **What is covered** – the services and supplies that are covered benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 4.)
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 4). However, your payroll deduction varies quite a bit (see page 17).
3. **Networks** – whether your provider or hospital has contracted with the insurance carrier. (See page 11.)
4. **Plan features** – how you access care and what kinds of "extras" the insurance carrier offers. Under some plans you must use network providers except in emergencies; others give you access to out-of-network providers. Finally, you may prefer one insurance carrier over the other (see pages 9 – 11).

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

Comparing Networks

When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you're like many people, you made a choice when you 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 doctor and receiving the same healthcare services?

Many doctors belong to multiple provider networks. Check to see if your doctor is a network provider under more than one of the plan options. Then, take a fresh look at your options. You may be able to save money every month without changing doctors.

Why Networks Matter

All of the plans cover the same healthcare services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Getting your care within the network provides the highest benefit level:

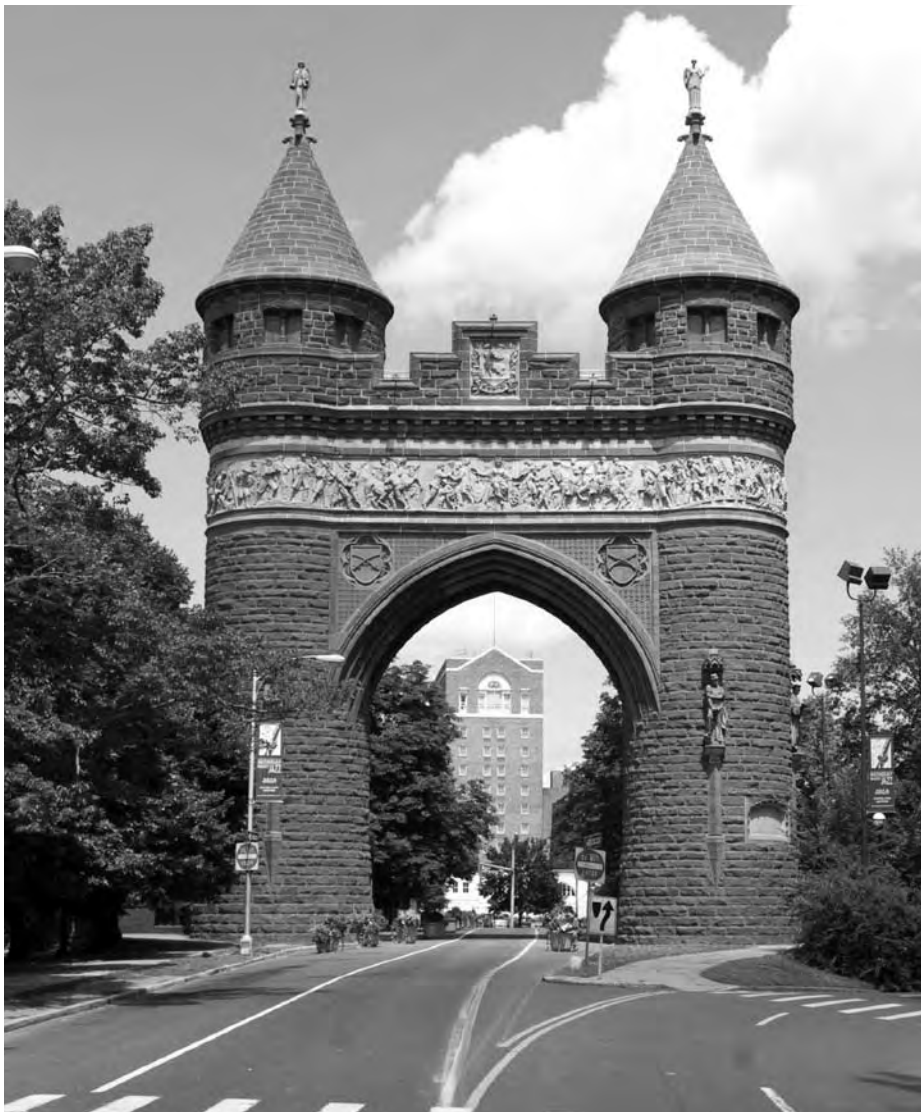
- If you choose a **Point of Enrollment (POE)** plan, you must use in-network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out-of-Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – but, you'll pay more for out-of-network services. Your in-network co-pays are also higher under a POS plan than under a POE or POE-G plan.
- If you choose a **Point of Enrollment - Gatekeeper (POE-G)** plan, you must use in-network providers for your care (except in emergencies) and you must obtain a referral for most specialist care.

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 to provide you with 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 the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. All plans have a national network available. Take a look at your options before you decide.



How the Plans Work

Point of Service (POS) Plans – These plans offer 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.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 18).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 18).

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 pre-certification 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 pre-certification (see page 4), 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 healthcare.

Where You Live or Work Affects Your Choices

You must live or work within a plan's regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the Oxford regional provider network. If you live and work outside that area, you should choose one of the Out-of-Area plans. Both Out-of-Area plans give you access to a national provider network.

Comparing Plan Features

All State of Connecticut plans cover the same 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 provide you access to out-of-network providers when you pay more of the fees. Some require you to select a Primary Care Physician (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 18 for phone numbers and websites.)
- **Discounts** – Both insurance carriers offer discounts to members for certain health-related expenses such as gym memberships and eyeglasses.

	POINT OF ENROLLMENT – GATEKEEPER (POE-G) PLANS		POINT OF ENROLLMENT (POE) PLANS		POINT OF SERVICE (POS) PLANS			OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford USA
National network	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available					X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X					
No referrals required for care from in-network providers			X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X							

* Closed to enrollment.

Frequently Asked Questions

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

All medical plans offered by the State of Connecticut cover the same services and supplies. For more detailed benefit descriptions and information about how to access the plan's services, contact the insurance carriers at the phone numbers or websites listed on page 18.

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's the difference between a service area and a provider network?

A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less when you use providers in the network.

What are my options if I want access to doctors across the U.S.?

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

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

Can I enroll later or switch plans mid-year?

Generally, the elections you make now are in effect through June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 3). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

Q&A

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 Prescription Drug Coverage at a Glance

Your prescription drug coverage is through Caremark. Prescription benefits are the same no matter which medical plan you choose.

Maintenance Medications

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long term. See page 7 for details on maintenance medications.

The plan has a 3-tier co-pay structure which means the amount you pay depends on whether your prescription is for a generic drug, a brand-name drug listed on Caremark's preferred drug list (the formulary), or a non-preferred brand-name drug.

PRESCRIPTION DRUG CO-PAYS ARE AS FOLLOWS EFFECTIVE OCTOBER 1, 2011:

For...	Maintenance Drugs 90-Day Supply	Non-Maintenance Drugs 30-Day Supply
Tier 1: Generic drug	$5	$5
Tier 2: Preferred brand-name drug	$10	$20
Tier 3: Non-preferred brand-name drug	$25 ($10 if your physician certifies the non-preferred brand-name drug is medically necessary)	$35 ($20 if your physician certifies the non-preferred brand-name drug is medically necessary)

For those enrolled in the Health Enhancement Program, medications used to treat chronic conditions covered by the Program's disease education and counseling programs cost even less:

- $0 co-pay for Tier 1 (generic)
- $5 co-pay for Tier 2 (preferred)
- $12.50 co-pay for Tier 3 (non-preferred).

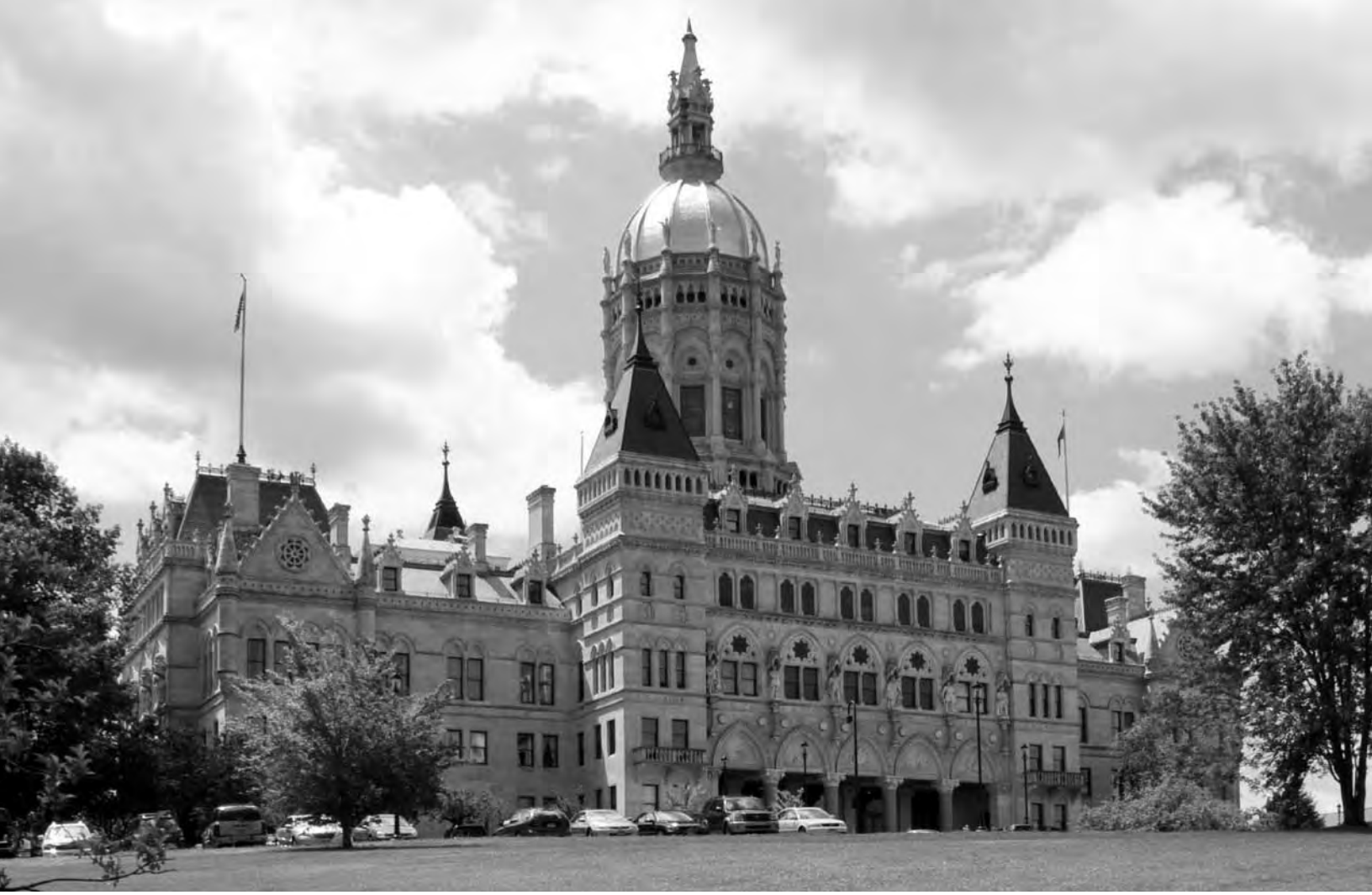
There is zero co-pay for medications and supplies used to treat diabetes (Type 1 and Type 2).

To check which co-pay amount applies to your prescriptions, visit www.Caremark.com for the most up-to-date information. Once you register, click on "Look up Co-pay and Formulary Status." Simply type the name of the drug you want to look up and you will see the cost and co-pay amounts for that drug as well as alternatives.

Preferred and Non-Preferred Brand-Name Drugs

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

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



If You Choose a Brand-Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted on page 14, if you choose a brand-name drug over a generic alternative and it is not approved as medically necessary, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572.

Mandatory 90-day Supply for Maintenance Medications

If you or your family takes a maintenance medication, you will be able to get your first 30-day fill of that medication at any participating pharmacy. After that your two choices are:

- Receive your medication through the Caremark mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the state's new Maintenance Drug Network (all CVS pharmacies will participate and other participating pharmacies will be announced on the Comptroller's website at www.osc.ct.gov when available).

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

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.

Your Dental Plan Choices at a Glance

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

* If enrolled in the Health Enhancement Program, annual dental cleanings (up to two) and unlimited periodontal care is provided.

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

Terms to Know

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

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

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

Before starting extensive dental procedures for which the dentist's charges may exceed $200, your dentist may 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 18.)

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

Your 2011-2012 Payroll Deductions

Bi-Weekly Payroll Deductions (if you enroll in the Health Enhancement Program) – 26 Pay Periods – July 1, 2011 through June 30, 2012

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

MEDICAL PLANS	EMPLOYEE	EMPLOYEE +1	FAMILY	FLES**
Point of Enrollment – Gatekeeper Plans (POE-G)				
Anthem State BlueCare POE Plus	$23.43	$67.76	$87.06	$45.56
UnitedHealthcare Oxford HMO	$17.43	$49.92	$64.14	$33.57
Point of Enrollment Plans (POE)				
Anthem State BlueCare	$25.74	$77.54	$103.22	$51.81
UnitedHealthcare Oxford HMO Select	$20.53	$61.86	$82.34	$41.33
Point of Service Plans (POS)				
Anthem State BlueCare	$33.19	$114.66	$132.48	$59.41
Anthem State Preferred POS*	$79.38	$231.84	$272.49	$158.94
UnitedHealthcare Oxford Freedom Select	$26.93	$93.04	$107.50	$48.21
Out of Area Plans (OOA)				
Anthem OOA	$33.19	$114.66	$132.48	$59.41
UnitedHealthcare Oxford USA	$26.93	$93.04	$107.50	$48.21
DENTAL PLANS	Dental rates effective October 1, 2011 through June 30, 2012			
UnitedHealthcare Basic	$0.00	$13.08	$13.08	$6.70
UnitedHealthcare Enhanced	$0.00	$12.03	$12.03	$6.16
Cigna DHMO®	$0.00	$4.29	$6.07	$2.50

* Closed to new enrollment.

** 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. **For employees enrolled in FLES: to participate in the Health Enhancement Program, both employees must enroll.**

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
- $150 each pay period saves you.....$3,900 per year

If you do not enroll in the Health Enhancement Program, an additional $46.16 will be deducted from your paycheck bi-weekly.

Your Benefit Resources

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

Anthem Blue Cross and Blue Shield • Anthem State Preferred POS (POS)* • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area	**www.Anthem.com/statect**	**1-800-922-2232**	
UnitedHealthcare (Medical) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford USA Out-of-Area	**www.OXHP.com/stateofct**	**1-800-760-4566**	
Caremark (Prescription drug benefits, any medical plan)	**www.Caremark.com**	**1-800-318-2572**	
UnitedHealthcare (Dental) • Basic Plan • Enhanced PPO	**www.Myuhcdental.com/statect**	**1-800-896-4834**	
CIGNA • DHMO Plan	**www.Cigna.com**	**1-800-244-6224**	

* Closed to new enrollment.