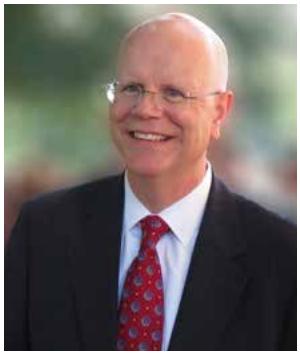
2021/2022 Health Care Options Planner

State of Connecticut Active Employees

CARE COMPASS

CareCompass.CT.gov



Kevin Lembo
State Comptroller
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Welcome!

Open Enrollment offers a great opportunity to evaluate your health care choices. We all make decisions every day that impact our health, well-being and personal finances. The choices you make during Open Enrollment are an extension of that.

Even if you're happy with your current coverage, it's a good idea to review your options to understand your must-haves and see if a different plan choice might meet your health care and budgetary needs.

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

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

Kevin Lembo

Connecticut State Comptroller

COVID-19 Vaccination

You pay nothing ($0) for a COVID-19 vaccination. It's covered 100% by the state's plan. For eligibility information, visit **cdc.gov** or **ct.gov**.

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What's New Starting July 1, 2021

Dental Plan Expansion

We're expanding our dental plan options to include a new Total Care Dental Health Maintenance Organization (Total Care DHMO) plan. The Total Care DHMO covers exams and routine care, periodontics, simple restoration (fillings), oral surgery and more! Instead of a copay, you'll pay coinsurance when you need care. Plus, there's no annual deductible or calendar-year benefit maximum! See page 14 for more information about this new plan.

Medical and Dental Plan Premiums

Premiums for the medical and dental plans are changing. See page 16.

Upswing Health

Is pain keeping you up at night? Is a nagging injury slowing you down? Talk to a professional at Upswing Health for help with non-emergency orthopedic injury, including tendinitis, sprains, carpal tunnel syndrome, arthritis and more. Learn more on page 9.

Virtual Appointments Available Through Anthem's LiveHealth Online

Using LiveHealth Online, you can see a doctor, licensed therapist or psychiatrist on your video-enabled smartphone, tablet or computer. For preventive care and HEP chronic disease visits, a $0 copay applies. For sick and mental health visits, a $5 copay applies. See page 9 for more information.

What You Need to Do

Current Employees

Open Enrollment Is May 3 Through May 28, 2021.

Now is your opportunity to review and learn about your health care 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.

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.

New! If you'd like to make a change for 2021/2022, upload the manual change form (CO-744A)—available from **CareCompass.CT.gov** or by contacting your agency HR. The CO-744A form is a fillable PDF that can be signed electronically and faxed, emailed or dropped off at your agency HR office.

What Happens if I Don't Make a Change?

If you're currently enrolled, your coverage will continue as is, with applicable 2021/2022 premiums.

If you are not enrolled, your coverage will continue to be waived.

IMPORTANT! Be sure to review all the plans available to you before making a final decision.

New Employees

To enroll for the first time, follow these steps:

1. Review this Planner, and choose the medical and dental options that best meet your needs.
2. Complete the enrollment form (available from your agency's Payroll/Human Resources office).
3. Return the completed 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, 2022, unless you have a qualifying status change (see Midyear Coverage Changes).

Midyear Coverage Changes

Once you make your coverage elections, you cannot make changes for the 2021/2022 plan year unless you have a qualifying status change, which includes changes in:

- **Legal marital/civil union status**, including marriage, civil union, divorce, death of a spouse and legal separation
- **Number of dependents**, including changes through birth, death, adoption, and legal guardianship
- **Employment status**, including events that change your or your dependents' employment status and 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**, including events that cause your dependent to become eligible or ineligible for coverage
- **Residence**, including moving out of the area you live in now that makes it difficult or impossible to see network providers
- **Loss of coverage**, including events that cause you or your dependents to lose coverage from another source

If you have a qualifying status change, you must notify your agency Payroll/Human Resources office **within 31 days** of the date of the event. The change you make must be consistent with your change in status. For example, if you have a child, you can add him or her to your current health care coverage, but you can't change the plan(s) in which you are enrolled. All coverage changes are effective the first day of the month following the date of the event.

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

> Find more information about 2021 Open Enrollment on **CareCompass.CT.gov** or by contacting your agency Payroll/Human Resources office.

Eligibility for Coverage

Dependents you can cover under your plans generally include:

- Your legally married spouse or civil union partner
- Your children:
  - Medical coverage through the end of the year in which they become age 26
  - Dental coverage through the end of the month in which they become age 19
- Children living with you for whom you are legal guardian (to age 18) unless proof of continued dependency is provided

Coverage eligibility for disabled children beyond age 26 for medical or age 19 for dental must be verified through Anthem. Contact their Enhanced Dedicated Member Services team at 800-922-2232 for details.

Documentation of an eligible relationship is required when you enroll a family member.

Visit **CareCompass.CT.gov** for details about dependent eligibility.

Make Sure You Cover Only Eligible Dependents

It is your responsibility to notify your agency's Payroll/Human Resources office if your family status changes and individuals you cover are no longer eligible.

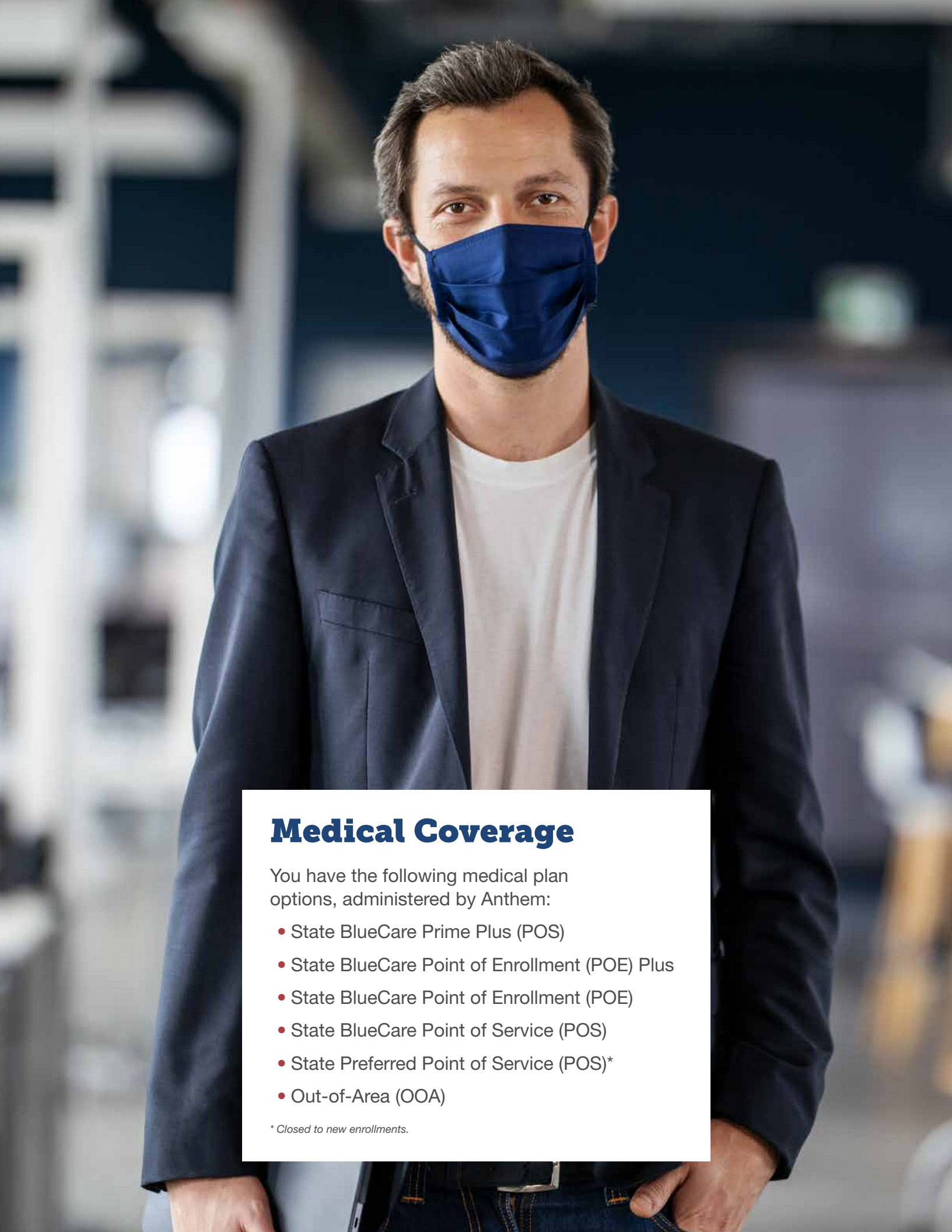
If you are covering an ineligible dependent, you must pay federal and state taxes on the fair market value of benefits provided to that person. It can cost you quite a bit if you continue to cover an ineligible person!

Medicare Eligibility

If you are an active employee and you and/or your spouse are eligible for Medicare, you do **not** need to enroll in Medicare Part B while you are enrolled in the active state plan. The active state plan is primary. If you choose to enroll in Medicare Part B, you will pay a premium for that coverage. The state does not reimburse Medicare Part B premiums for employees or dependents enrolled in the active state plan.

Generally, you don't pay a premium to have Medicare Part A.

When your active employee state coverage ceases (for example, when you retire), you will have a limited time to sign up for Medicare Part B with no penalty. If you are eligible for the state's retiree plan, you will be required to enroll in Medicare Part B at that time. You must submit a copy of your Medicare card to the Office of the State Comptroller's Retirement Health Unit for reimbursement of your and/or your spouse's Medicare Part B premium.



Medical Coverage

You have the following medical plan options, administered by Anthem:

- State BlueCare Prime Plus (POS)
- State BlueCare Point of Enrollment (POE) Plus
- State BlueCare Point of Enrollment (POE)
- State BlueCare Point of Service (POS)
- State Preferred Point of Service (POS)*
- Out-of-Area (OOA)

** Closed to new enrollments.*

Understanding the Plans

State BlueCare Prime Plus POS Plan

With the State BlueCare Prime Plus POS plan, you'll save on your premiums by only using the highest-quality doctors, specialists and locations across the state.

If you enroll in this plan, you must select a primary care physician (PCP) and use providers in the State BlueCare Prime Plus POS Network to pay the least for covered services. Check **anthem.com/statect/find-care** to see if your current PCP or specialists are preferred providers with the plan.

Services received without a referral or from an out-of-network provider are reimbursed at 70% of the allowable cost (after you pay the annual deductible). Preferred PCPs and specialists in the network can be identified with the Anthem Tier 1 designation in the Anthem provider look-up tool. PCPs participating in the network are encouraged to refer you to Tier 1 providers when appropriate. Note: Hartford HealthCare facilities and doctors are not currently participating in the State BlueCare Prime Plus POS Network.

State BlueCare and State Preferred* Point of Service (POS) Plans

With these plans, you can use in-network or out-of-network providers. No referrals are necessary to receive care from in-network providers. Services received out-of-network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

State BlueCare Point of Enrollment (POE) Plan

This plan will only pay benefits if you receive care from a defined network of providers. Out-of-network care is only covered in an emergency. No referrals are necessary to visit an in-network provider.

State BlueCare Point of Enrollment (POE) Plus Plan

This plan will only pay benefits if you receive care from a defined network of providers. Out-of-network care is **only** covered in an emergency.

The main difference between this plan and the State BlueCare POE plan is that you must select a PCP to coordinate your care; referrals are required to see a specialist. You can designate any PCP who is in the network. For children, you may designate a pediatrician as their PCP. If you do not make a designation, the plan will designate a provider for you. For information on in-network PCPs and how to make a designation, contact Anthem.

** Closed to new enrollments*

Note: You do not need prior authorization for obstetrical or gynecological care from an in-network provider who specializes in obstetrics or gynecology. Certain procedures may require prior authorization. For a list of in-network providers specializing in obstetrics or gynecology, contact Health Navigator.

> **Allowable Charge**
>
> If you visit an out-of-network provider, the allowable charge is the amount your plan would pay had you visited an in-network provider. When you visit an out-of-network provider, you are responsible for all charges above the allowable charge, up to that provider's usual charge for those services.

Making Your Decision

All the medical plans cover the same medical benefits, services and supplies. What you pay for covered services and where you can go to receive care differ, including referral requirements and provider networks.

When making your plan decision, consider:

- **Network:** With the State BlueCare Prime Plus POS plan, you must receive and follow referrals from your selected primary care physician (PCP) for specialty and other non-emergency care to receive the reduced in-network cost share. PCPs participating in this plan are encouraged to refer you to a preferred or Tier 1 specialist (providers that meet the state's rigorous standards for delivering quality, cost-effective care). The POS, Preferred POS, and Out-of-Area plans provide in-network and out-of-network coverage. The State BlueCare POE Plus and State BlueCare POE plans only pay for services received in-network, unless you need care due to an emergency.
- **Primary care physicians:** The State BlueCare POE Plus and State BlueCare Prime Plus POS plans require you to choose a PCP who will coordinate your care. The other plans do not require you to designate a PCP.
- **Referrals:** The State BlueCare POE Plus and State BlueCare Prime Plus POS plans require you to get a referral before you receive care from a specialist. The other plans do not require referrals; however, you will pay more if you are enrolled in the State BlueCare Prime Plus POS plan and do not get a referral.
- **Costs:** There are differences in what you pay when you receive care, depending on whether you choose a Network of Distinction provider, another in-network provider or an out-of-network provider. Review the table on pages 6 and 7 to see a comparison. What you pay in premiums varies significantly depending on the plan you select and whom you choose to cover.

Medical Plans at a Glance

Here's how much you pay for covered services depending on the plan you're enrolled in and where you choose to receive care.

Benefit Features		State BlueCare Prime Plus POS			State BlueCare POE Plus State BlueCare POE	State BlueCare POS and State Preferred[1] POS Out-of-Area	
		In-Network with PCP Referral	In-Network Without PCP Referral	Out-of-Network[2]	In-Network ONLY	In-Network	Out-of-Network[2]
Annual deductible	**Individual**	$350[3]	$1,000		$350[3]	$350[3]	$300
	Family	$1,400[3]	$4,000		$350 each member[3] ($1,400 maximum)	$350 each member[3] ($1,400 maximum)	$900
Annual out-of-pocket maximum	**Individual**	$3,000	$5,000		$2,000	$2,000	$2,000 (plus deductible)
	Family	$6,000	$10,000		$4,000	$4,000	$4,000 (plus deductible)
Preadmission authorization/concurrent review		By participating provider	By participating provider		By participating provider	By participating provider	20% penalty (max. $500) for no authorization
Outpatient physician visits, walk-in centers		Plan pays 100%	30%	30%	Value Tier 1 Provider: Plan pays 100% Network of Distinction Tier 2 Provider: $15 copay[4]	Value Tier 1 Provider: Plan pays 100% Network of Distinction Tier 2 Provider: $15 copay[4]	20%
LiveHealth Online (telemedicine)		Preventive care and HEP visits: $0 copay Sick and mental health visits: $5 copay		N/A	Preventive care and HEP visits: $0 copay Sick and mental health visits: $5 copay	Preventive care and HEP visits: $0 copay Sick and mental health visits: $5 copay	N/A
Preventive care		Plan pays 100%	Plan pays 100%	30%	Plan pays 100%	Plan pays 100%	20%
Emergency care		$250 copay[5,6]	$250 copay[5,6]	$250 copay[5,6]	$250 copay[5]	$250 copay[5]	$250 copay[5]
Diagnostic x-ray and lab (prior authorization required for diagnostic imaging)		Preferred Provider: Plan pays 100%[6] Other location: 20%[6]	Preferred Provider: Plan pays 100%[6] Other location: 20%[6]	40%[6]	Preferred Provider: Plan pays 100% Other location: 20%	Preferred Provider: Plan pays 100% Other location: 20%	40%[3]
Preadmission testing		Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Inpatient physician (prior authorization required)		Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%

[1] Closed to new enrollments

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

[3] Waived for HEP-compliant members

[4] $0 copay for Preferred Providers. See page 9 for more details.

[5] Waived if admitted

[6] No referral required

Benefit Features	State BlueCare Prime Plus POS			State BlueCare POE Plus State BlueCare POE	State BlueCare POS and State Preferred[1] POS Out-of-Area	
	In-Network with PCP Referral	In-Network Without PCP Referral	Out-of-Network[2]	In-Network ONLY	In-Network	Out-of-Network[2]
Inpatient hospital (prior authorization required)	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Outpatient surgical facility (prior authorization required)	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Ambulance (if emergency)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Short-term rehabilitation and physical therapy (prior authorization may be required)	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%, up to 60 inpatient days, 30 outpatient days per condition per year
Routine eye exam (one exam per year)	$15 copay[4,7]	$15 copay[4,7]	$15 copay[4,7]	$15 copay[4,7]	$15 copay[4,7]	50%
Audiology screening (one exam per year)	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	20%
Mental Health/Substance Abuse						
Inpatient (prior authorization required)	Plan pays 100%	Plan pays 100%	30%	Plan pays 100%	Plan pays 100%	20%
Outpatient	Plan pays 100%[6]	Plan pays 100%	30%[6]	$15 copay	$15 copay	20%
Family Planning (prior authorization may be required)						
Vasectomy	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Tubal ligation	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Durable medical equipment (prior authorization may be required)	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Hearing aids (limited to one set of hearing aids within a 36-month period)	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Prosthetics (prior authorization may be required)	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%
Skilled nursing facility (prior authorization required)	Plan pays 100%	30%	30%, up to 60 days per year	Plan pays 100%	Plan pays 100%	20%, up to 60 days per year
Home health care (prior authorization required)	Plan pays 100%	30%, up to 200 visits per year		Plan pays 100%	Plan pays 100%	20%, up to 200 visits per year
Hospice (prior authorization required)	Plan pays 100%	30%	30%	Plan pays 100%	Plan pays 100%	20%, up to 60 days

[1] Closed to new enrollments

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

[4] $0 copay for Preferred Providers. See page 9 for more details.

[6] No referral required

[7] Health Enhancement Program participants have $15 copay waived once every two years.

Using Your Benefits

The state has provided some programs and tools that you can use to maximize your benefits and get help making important health care decisions.

Care Compass

Care Compass is your one-stop shop for everything related to your state benefits! This website has all the information you need—including benefit charts, plan documents, carrier contact information and more! Visit **CareCompass.CT.gov** today.

Health Navigator

You and any enrolled dependents can contact Health Navigator for help understanding your benefits, finding a doctor, and dealing with the complexities of health care. The support you'll receive from Health Navigator will be highly coordinated with the member services teams at Anthem, Cigna, CVS Caremark and Care Management Solutions to make it easier for you to navigate your benefits and access the right care for you.

Health Navigator has an online search tool to help you find the best-quality providers and locations for certain procedures in the Network of Distinction. By registering, you may also be eligible for a cash incentive.

To use the Health Navigator tool:

1. Visit **CareCompass.CT.gov/nod**.
2. Select your plan (located on the back of your Anthem ID card).
3. Search for a procedure, provider or facility.

Network of Distinction providers are indicated with a silver trophy. If a cash incentive is available for using a certain provider, it will be listed next to the doctor's or location's name. The highest-quality Network of Distinction providers and facilities are labeled as Centers of Excellence and will be marked with a gold star. The largest incentives are available for receiving care at a Center of Excellence, where available.

To be eligible for an incentive, you must call Health Navigator to confirm your choice. They can help answer any questions about this program and even assist you in making your appointment.

> Chat with a professional Navigator 24 hours a day, seven days a week at 866-611-8005. Or use the online chat function on the Health Navigator web site: **CareCompass.CT.gov/navigator**.

Network of Distinction

The state of Connecticut has identified specific doctors, hospitals and provider groups that meet the highest patient care standards. These doctors and locations have been designated members of the new Network of Distinction. It's easier than ever to get the care you need by visiting a Network of Distinction provider for some of the most common medical conditions and procedures. Network of Distinction members can coordinate your care throughout your entire treatment process, from evaluation through recovery. By registering with a Health Navigator before your service or procedure, you may even be eligible for a cash incentive.

Find a provider. Use the online Health Navigator Search Tool at **CareCompass.CT.gov/nod** to search by procedure, provider and facility. You can also call Health Navigator for assistance finding a Network of Distinction location or provider, or use the Find Care tool on **anthem.com/statect** or the Sydney Health mobile app.

Earn incentives. If you use a Network of Distinction provider for a qualifying procedure, you can earn a cash reward! When you use the best-quality providers, you get the best care, and the state plan is more efficient because the risk of complications is reduced. Here's a list of some of the procedures eligible for a cash reward when performed by a Network of Distinction provider:

- Hip, shoulder and knee surgery
- Bariatric surgery
- Cardiac procedures
- Colonoscopies
- Prenatal care and delivery

Note: The amount of the reward varies by procedure and location.

Travel reimbursement. Depending on the distance traveled to obtain care from a Network of Distinction provider, you may be eligible for travel benefits. Contact Health Navigator to determine eligibility.

Site of Service Providers

You pay nothing—$0 copay—for lab tests, x-rays and other imaging services (such as MRIs and CT scans) if you visit a preferred Site of Service provider. To find a Site of Service provider, contact Anthem, or use the Find Care tool on **anthem.com/statect** or the Sydney Health app.

Upswing Health

Upswing Health is your go-to for help with non-emergency orthopedic injury, including tendinitis, sprains, carpal tunnel syndrome, arthritis and more.

Use Upswing to:

- Learn about treating injuries at home (i.e., how to treat a sprained ankle, sudden back spasm, or a pulled muscle).
- Consult with a doctor over video or phone.
- Get a custom, video-based rehab/exercise program emailed directly to you.
- Expedite your care with a referral to a physician for in-person evaluation or testing, if needed.
- Check on your progress and recovery.

To get started, contact Upswing at 203-204-3855 or **info@upswinghealth.com**. You can learn more about the program at **upswinghealth.com/CT**.

You're covered anywhere you go!

If you travel outside Connecticut but are in the U.S., you have access to doctors and hospitals across the country with the BlueCard® program. If you travel outside the U.S., you have access to providers in nearly 200 countries with the Blue Cross Blue Shield Global Core® program. Call 800-810-2583 to learn more about both programs. If you're outside the U.S., call collect at 804-673-1177.

Sydney Health Mobile App

With the Sydney Health app, you can find everything you need to know about your benefits in one place. Plus, you can now connect with the Sydney Care™ app for a convenient way to get health answers and find affordable care when you need it. Services include:

- **Virtual visits.** Connect with a doctor who can help diagnose your condition, prescribe medications, and recommend follow-up care. You'll pay nothing for a virtual (telehealth) preventive care visit with your doctor.
- **Verify coverage.** Use Sydney Health to check your benefits, review your claims and ID cards, and get fast answers using the interactive chat feature.
- **My Health Dashboard.** Complete the health assessment to get a personalized action plan based on your wellness priorities. Then, watch videos and read tips to live healthy, and find nutritionist-approved recipes and meal plans.
- **Symptom checker.** Not feeling well? See how others with similar symptoms were treated using an interactive chat. In just minutes you'll have reliable, personalized results.
- **Care Market.** Find and schedule in-person appointments with select Network of Distinction care providers.

Download the Sydney Health app from the App Store or Google Play.

LiveHealth Online

LiveHealth Online connects you with a board-certified doctor for a video visit using your smartphone, tablet or computer. Doctors can answer your questions and assess illnesses such as sore throats, ear infections, pinkeye and the flu. They can even send a prescription to your pharmacy, if needed.

Get started by going to **livehealthonline.com** or downloading the free app. Spanish-speaking members can use Cuidado Médico through LiveHealth Online to schedule a video visit with a Spanish-speaking doctor, 7 a.m. to 11 p.m., seven days a week. Site registration is required. For preventive care and HEP chronic disease visits, a $0 copay applies. For sick and mental health visits, a $5 copay applies.

Make an appointment for mental health-related concerns.

LiveHealth Online therapists are available seven days a week to discuss anxiety, depression, stress, grief, eating disorders and other mental health concerns. Call 844-784-8409 to schedule an appointment.

Health Enhancement Program

The Health Enhancement Program (HEP) helps you and your family stay healthy. Plus, it saves you and the state money on health care costs. It's your choice to participate, but there are many advantages to doing so.

Save Money by Participating!

When you and all your enrolled family members participate in HEP, you will pay lower monthly premiums and have no in-network deductible for the plan year.

If you or an enrolled family member has one of the five chronic conditions listed to the right and you complete the HEP requirements, you may receive a $100 incentive. Also, you can save money on prescription drugs to treat your chronic condition.

How to Enroll

Current Employees

If you are not currently participating in HEP, you can enroll during Open Enrollment. Form (CO-1314) is available at your agency's Payroll/Human Resources office or by visiting **CareCompass.CT.gov/forms**.

Those enrolled in 2020 will automatically be re-enrolled for 2021/2022.

New Employees

If you are a new employee, you must complete the HEP enrollment form when you make your benefit elections. HEP enrollment form (CO-1314) is available at your agency Payroll/Human Resources office or by visiting **CareCompass.CT.gov/forms**. You will not have to meet HEP requirements until the first calendar year in which you are enrolled in coverage as of January 1. If you do not wish to participate in HEP, you can disenroll during Open Enrollment.

2021 Requirements

HEP enrollees and all family members must get age-appropriate wellness exams and early diagnosis screenings, such as colorectal cancer screenings, Pap tests, mammograms and vision exams.

Visit the HEP online portal at **cthep.com** to find out whether you have outstanding dental, medical or other requirements. **HEP requirements must be completed by December 31.** Those with chronic conditions can complete certain requirements online. Care Management Solutions, the administrator for HEP, may also be reached by phone at 877-687-1448.

Chronic Condition Requirements

You and/or that family member will be required to participate in a disease education and counseling program if you have:

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

You will receive free office visits and reduced pharmacy copays for treatments related to your condition. Your household must meet all preventive and chronic requirements to be compliant.

Preventive Screenings	Age						
	0 – 5	6 – 17	18 – 24	25 – 29	30 – 39	40 – 49	50+
Preventive visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50 – 64: Every 3 years 65+: Every 2 years
Dental cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 5 years
Breast cancer screening (mammogram)	N/A	N/A	N/A	N/A	N/A	1 screening between age 45 and 49**	As recommended by physician
Cervical cancer screening (Pap smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years, or Pap and HPV combo screening every 5 years	Every 3 years, or Pap and HPV combo screening every 5 years	50 – 65: Every 3 years, or Pap and HPV combo screening every 5 years
Colorectal cancer screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years, annual fecal immunochemical test and fecal occult blood test to age 75, or Cologuard screening every 3 years

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

*** Or as recommended by your physician*

Help Managing Diabetes

Manage your diabetes with help from the Livongo diabetes management program. Monitor your conditions through digitally connected devices, receive health nudges, and access 24/7 digital and live coaching, all from home, all at no cost through the state plan. Visit **join.livongo.com/CONNECTICUT** to learn more.

Diabetes Prevention Program (DPP)

This is a 12-month program focused on improving lifestyle behaviors to reduce diabetes risk. The program brings powerful education and motivating support right to your computer, smartphone or tablet.

- Participants join live digital classes at a regularly scheduled day and time with a certified health coach who provides education on preventing diabetes.
- On-demand classes to help adhere to the plan on your schedule.
- Individualized coaching support available.
- Online challenges to create new, healthy habits.
- Tools to help live a healthy lifestyle.

Contact a HEP representative at 877-687-1448 or **HEPquestions@Connect2YourHealth.com**. You can find more information about the program, including a link to the online CDC diabetes risk questionnaire, at **CareCompass.CT.gov/diabetes**.

More Information

Care Management Solutions offers a website with tips and tools to help you manage your health and your HEP requirements. Visit **cthep.com** to:

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

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

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

> If it is your first time on the participant portal, you will need to create an account. All participants over the age of 18 will need to create their own account.

Prescription Drug Coverage

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

There is a four-tier copay structure. The amount you pay depends on whether your prescription is for a generic drug, a brand name drug listed on CVS Caremark's preferred drug list (the formulary), or a non-preferred brand name drug.

Here's what you'll pay for covered prescription drugs, depending on the tier and where you choose to fill your prescription.

	Maintenance Drugs 90-Day Supply	Non-Maintenance Drugs 30-Day Supply
Tier 1: Preferred generic	$5	$5
Tier 2: Non-preferred generic	$10	$10
Tier 3: Preferred brand name	$25	$25
Tier 4: Non-preferred brand name	$40*	$40*

** $25 if your physician certified the non-preferred brand name drug is medically necessary*

If you are enrolled in the Health Enhancement Program, you'll pay lower copays for medications used to treat chronic conditions covered by HEP's disease education and counseling programs:

- Tier 1: $0 copay
- Tier 2: $5 copay
- Tier 3: $12.50 copay

You'll pay nothing for medications and supplies used to treat diabetes (type 1 and type 2).

To check which copay amount applies to your prescriptions, visit **Caremark.com**. Once you register, click **Look up Copay** and **Formulary Status**. Type the name of the drug you want to look up, and you will see the cost and copay amounts for that drug as well as alternatives.

Brand Name Drugs

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

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 **CareCompass.CT.gov**) and fax it to CVS Caremark. If approved, you will pay the preferred brand copay amount.

Mandatory Generics

Prescriptions will be filled automatically with a generic drug if one is available, unless your doctor completes CVS Caremark's Coverage Exception Request form and it is approved. Note: It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required. If you request a brand name drug instead of a generic alternative without obtaining a coverage exception, you will pay the generic drug copay PLUS the difference in cost between the brand and generic drug.

90-Day Supply for Maintenance Medications

If you or your family member takes a maintenance medication, you are required to get your maintenance prescriptions as 90-day fills. You can get your first 30-day fill of a new medication at any participating pharmacy. After that, your two choices are:

- Receive your medication through the CVS Caremark mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the state's Maintenance Drug Network (see the list of participating pharmacies on **CareCompass.CT.gov**).

A list of maintenance medications is posted at **CareCompass.CT.gov**.

> **Maintenance Medications**
>
> Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long term.

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 to take the medication. Call 800-237-2767 for information.

Contact CVS Caremark

If you have questions about your prescription drug benefits, visit **Caremark.com** or call CVS Customer Care at 800-318-2572.

Dental Plan Coverage

Dental coverage ends for dependent children at age 19 (unless disabled*). Cigna is the administrator for all State of Connecticut dental plans:

- ***New!* Total Care DHMO Plan.** This plan provides dental services only from a defined network of dentists and pays benefits only when you receive care from a network dentist (except in cases of emergency). You must select a primary care dentist; they will coordinate your care. Referrals are required for all specialist services. There's no annual deductible or calendar-year maximum. When you need care, you pay coinsurance based on the service you receive.
- **Enhanced Plan.** This plan pays benefits for services received in- and out-of-network, without a referral. When you visit an out-of-network dentist, you are responsible for all charges above the maximum allowable charge—the amount the plan would have paid if you had visited an in-network dentist. That means your out-of-pocket expenses may be higher if you see a dentist who is not part of the Cigna PPO Network.
- **Cigna Dental Care 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. There's no annual deductible or calendar-year maximum. When you need care, you pay copays based on the service you receive.
- **Basic Plan.** This plan allows you to visit any dentist or dental specialist without a referral.

Here's what you'll pay for covered dental services, depending on the plan you elect.

	Total Care DHMO Plan (network only)	Enhanced Plan (network)	Cigna Dental Care DHMO Plan (network only)	Basic Plan (any dentist)
Annual deductible	None	Individual: $25 Family: $75	None	None
Annual maximum	None	$3,000 per person (excluding orthodontia)	None	None
Exams, cleanings and x-rays	Plan pays 100%	Plan pays 100%, deductible does not apply[1]	Plan pays 100%	Plan pays 100%
Periodontal maintenance[2]	15% coinsurance, plan pays 85%	Plan pays 100%[1]	Copay[3]	20% (if enrolled in HEP, plan pays 100%)
Periodontal root scaling and planing[2]	15% coinsurance, plan pays 85%	20%	Copay[3]	50%
Other periodontal services	15% coinsurance, plan pays 85%	20%	Copay[3]	50%
Simple Restoration				
Fillings	15% coinsurance, plan pays 85%	20%	Copay[3]	20%
Oral surgery	15% coinsurance, plan pays 85%	20%	Copay[3]	33%
Major Restorations				
Crowns	30% coinsurance, plan pays 70%	33%	Copay[3]	33%
Dentures, fixed bridges	45% coinsurance, plan pays 55%	50%	Copay[3]	Not covered[4]
Implants	45% coinsurance, plan pays 55% (one per year)	50% (plan pays benefits up to $500)	Copay[3]	Not covered[4]
Orthodontia	45% coinsurance, plan pays 55%	50%, plan pays maximum of $1,500 per person per lifetime[5]	Copay[3]	Not covered[4]

** For your disabled child to remain an eligible dependent, he or she must be certified as disabled by Anthem before he or she becomes age 19 (for dental benefits; age 26 applies only for medical benefits).*

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

[2] If you're enrolled in the Health Enhancement Program (HEP), frequency limits and cost share are applicable.

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

[4] While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 15 for details).

[5] Benefits are prorated over the course of treatment.

Consider the Cigna Dental Care DHMO Plan or the Total Care DHMO Plan

The DHMO network continues to grow! Did you know that many retirees enrolled in the Basic and Enhanced plans are already seeing DHMO providers? Be sure to check your provider's status at **cigna.com/stateofct**.

Enrolling in the DHMO could help you save money.

Oral Health Integration Program

Employees (including dependents) enrolled in a State of Connecticut dental plan are eligible for Cigna's Oral Health Integration Program (OHIP). OHIP provides 100% reimbursement of copays for select covered services to members with qualifying medical conditions.

If you are pregnant or have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation), you are encouraged to enroll in this program to reduce your costs. More information can be found at **CareCompass.CT.gov**.

Need help choosing a dental plan?

Try Cigna's decision support tool: **zingtree.com/show/233326574000**.

Savings on Non-Covered Services

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

You must visit a network dentist to receive these discounts. And you should verify that the procedure is listed on the dentist's fee schedule before receiving treatment. You are responsible for paying the negotiated fee directly to the dentist.

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

Pretreatment Estimates

Before starting extensive dental procedures where charges may exceed $200, your dentist may submit a pretreatment estimate to the plan. You can also help to determine the amount you will be required to pay for a specific procedure at **CareCompass.CT.gov**.

myCigna Mobile App

Download the myCigna mobile app on Google Play (Android) or the App Store (Apple) to get access to your personal information on the go. Through the app, you can find care and costs, view claims, update your personal information and more!

2021/2022 Payroll Deductions

Biweekly Payroll Deductions

July 1, 2021 Through June 30, 2022 (26 Pay Periods)

If you do not enroll in HEP, you'll pay an additional $46.15 per paycheck for the cost of coverage. (Employees on semimonthly pay schedules will have slightly higher premiums.)

Union

Medical Plans	Employee	Employee + 1	Family	FLES**
State BlueCare Prime Plus POS	$35.35	$95.06	$121.97	$70.12
State BlueCare POE Plus	$44.99	$121.38	$154.37	$84.41
State BlueCare POE	$48.87	$136.82	$173.13	$94.36
State BlueCare POS	$57.90	$155.69	$179.87	$102.48
State Preferred POS*	$101.66	$296.89	$348.96	$203.55
Out-of-Area	$61.29	$190.00	$222.26	$108.16

New Hires (Hired After July 1, 2017)

Medical Plans	Employee	Employee + 1	Family	FLES**
State BlueCare Prime Plus POS	$35.35	$95.06	$121.97	$70.12
State BlueCare POE Plus	$44.99	$121.38	$154.37	$84.41
State BlueCare POE	$48.87	$136.82	$179.19	$94.36
State BlueCare POS	$57.90	$155.69	$184.78	$102.48
State Preferred POS*	N/A	N/A	N/A	N/A
Out-of-Area	$61.42	$190.44	$222.76	$108.38

Non-Union

Medical Plans	Employee	Employee + 1	Family	FLES**
State BlueCare Prime Plus POS	$70.70	$155.55	$190.91	$120.20
State BlueCare POE Plus	$75.66	$166.46	$204.29	$128.63
State BlueCare POE	$76.94	$169.28	$207.75	$130.80
State BlueCare POS	$76.99	$169.38	$207.88	$130.88
State Preferred POS*	$104.04	$228.90	$280.93	$176.88
Out-of-Area	$104.04	$228.90	$280.93	$176.88

Dental Plans	Employee	Employee + 1	Family	FLES**
Basic	$0.00	$12.27	$12.27	$6.29
Enhanced	$0.00	$10.37	$10.37	$5.31
Cigna Dental Care DHMO	$0.00	$4.10	$5.81	$2.39
Total Care DHMO	$0.00	$5.11	$7.25	$2.99

** Closed to new enrollment*

*** The Family Less Employed Spouse (FLES) rate is available only when both spouses are enrolled in active coverage, eligible for health insurance, and enrolled in the same plan, along with at least one child. If you are enrolled in the FLES coverage level, both you and your spouse must enroll in order to participate in the Health Enhancement Program.*

Frequently Asked Questions

Where can I learn more about what the state health insurance plan covers?

All medical plans offered by the State of Connecticut cover the same services and supplies. For questions, please contact a state Health Navigator: 866-611-8005.

Can I enroll after Open Enrollment or when I'm first eligible for coverage, or switch plans midyear?

The elections you make at Open Enrollment or when you're first eligible for coverage are in effect through June 30, 2022. If you have a qualifying status change, you may be able to change your elections midyear (see page 2).

If you decline coverage now, you may enroll during any future Open Enrollment period or if you experience certain qualifying status changes.

Can I enroll myself in one option and my eligible 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. 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.

My spouse and I will be eligible for Medicare soon. Should I sign up for Medicare? What else do I need to do?

If you are enrolled in the active health insurance plan as an active employee or a dependent of an active employee, you don't need to sign up for Medicare Part B. The state employee active health plan is primary, and Medicare is secondary as long as you're enrolled as an active employee. This means that Medicare will only pay for services after your employee plan has paid.

Medicare Part A does not typically have a premium cost associated with enrollment.

When you and your spouse (if applicable) cease enrollment in the active employee state plan (i.e., upon retirement), you will have a limited time to sign up for Medicare Part B with no penalty.

How do I know which plan is best for me?

This is a question only you can answer. Each plan offers different advantages. To help choose which plan might be best for you, compare the plan-to-plan features in the chart on pages 6 and 7 for medical and page 14 for dental. You can also contact Health Navigator for help choosing the best medical plan for you and your enrolled family members.

Can my children be covered under my dental plan until age 26, like they can under my medical plan?

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

Do any of the dental plans cover orthodontia for adults?

Yes, the Total Care DHMO plan, Enhanced plan and Cigna Dental Care DHMO plan all cover orthodontia for adults. The Total Care DHMO plan covers 55% of the cost with an in-network provider. The Enhanced plan pays $1,500 per person per lifetime and covers 50% of the cost for adults and children. The Cigna Dental Care DHMO requires a set copay for in-network providers. The Basic plan does not cover orthodontia for adults or children.

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

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

What's the difference between the Cigna Dental Care DHMO Plan and the Total DHMO Plan?

If you're enrolled in the Cigna Dental Care DHMO Plan, you pay copays when you need care. If you're enrolled in the Total DHMO Plan, you pay coinsurance when you need care.

** For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before they turn age 19 for dental benefits or age 26 for medical benefits. Contact Anthem's Enhanced Dedicated Member Services team at 800-922-2232 for information.*

Your Benefit Resources

Contact Health Navigator for help understanding your benefits, finding a doctor, and dealing with the complexities of the health care. They should be your first call when you have a benefits-related question.

Phone: 866-611-8005
Website: **CareCompass.CT.gov**

Vendor	Website	Phone
General benefit questions	**CareCompass.CT.gov**	866-611-8005
Health Enhancement Program (HEP) Care Management Solutions	**cthep.com**	877-687-1448
Anthem Blue Cross and Blue Shield Enhanced Dedicated Member Services	**CareCompass.CT.gov** or **anthem.com/statect**	800-922-2232
CVS Caremark	**CareCompass.CT.gov**	800-318-2572
Cigna	**CareCompass.CT.gov**	800-244-6224

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