For State of Connecticut

Retirees

Retirement Date October 2, 2011 or Later

HEALTH CARE OPTIONS PLANNER

2013-2014

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New HEP Website
www.cthep.com

Create your account (even if you had one before), check your HEP compliance status, and check out the new features. Be sure that your spouse and any dependents age 18 and over also create an account.

See page 6.

A Message from State Comptroller Kevin Lembo

Our daily choices affect our health and what we pay out of pocket for our health care. Even if you're happy with your current coverage, it's a good idea to review the plan options each year during open enrollment.

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

During this open enrollment, if you have not previously enrolled in the Health Enhancement Program (HEP), you must decide if you want to participate in HEP for 2013-2014. HEP is designed to help you and your family work with your medical providers to make the best decisions about your health.

If you want to enroll in HEP, you must do so by June 7, 2013 or you will not be allowed to participate in HEP until the next open enrollment.

Those who participated in HEP during 2012-2013 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2013-2014 and will continue to pay lower premiums for their health care coverage. Retirees eligible to participate in HEP must have retired on or after October 2, 2011.

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 health care.

Kevin Lembo
State Comptroller
May 2013

2013-2014 Plan Year News

There are no benefit changes for 2013-2014.

2013-2014 premium shares are listed on page 11.

What You Need to Do

Current Retirees

Open Enrollment May 13 Through June 7, 2013

During open enrollment, you have the opportunity to adjust your healthcare benefit choices. It's a good time to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best value.

During open enrollment, you may change medical and/or dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage. If you have a question concerning your enrollment, contact the Retirement Health Insurance Unit at the address below or call (860) 702-3533.

Complete and return the form in the back of this booklet if you'd like to make a change for 2013-2014. The form must be postmarked by June 7, 2013. Any changes you make are effective July 1, 2013 through June 30, 2014 unless you have a qualifying status change. If you don't want to make changes, you don't need to do a thing; your current coverage will continue automatically at the rates listed on page 11.

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

Return completed enrollment forms to:

Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106

New Retirees

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 (Form CO-744 – Choice of Health Insurance After Retirement) included in your retirement packet; this form is different from the one included in this booklet for open enrollment.
3. Return the form with your retirement packet.

If you enroll as a new retiree, your coverage begins the first day of the second month of your retirement. For example, if your retirement date is October 1, your coverage begins November 1. If you waive coverage when you're initially eligible, you may enroll within 31 days of losing other coverage, or during any open enrollment period.

What to Do When You Become Eligible for Medicare

Retirees and dependents eligible for Medicare Part A (Hospital Insurance) must enroll in Medicare Part B (Medical Insurance), regardless of age. Your Medicare Part B premium will be reimbursed by the State effective from the date your Medicare Part B card is received by the Retirement Health Insurance Unit. (Medicare premiums paid before your card is received will not be reimbursed.) Be sure to send us a copy of your Medicare card as soon as you receive it. Medicare will become your primary coverage and this plan will pay after Medicare.

You will receive a letter from the Retirement Health Insurance Unit with more information when you reach age 65. If you become eligible for Medicare due to disability, be sure to contact us.

When you become eligible for Medicare, you will be automatically enrolled in the Silverscript prescription drug program. Your prescription benefits will stay the same but you use your Silverscript ID card for prescriptions instead. Be sure to review "When You Become Eligible for Medicare" in the prescription drug section of this book that applies to your retirement date. See page 9 for more information on prescription drugs for Medicare-eligible participants.

Make Sure You Cover Only Eligible Dependents

This planner provides a brief summary of covered expenses. See Your Benefit Resources on page 28 to receive more detailed information.

It's important to understand who you can cover under the plan. It's critical that the State only provide coverage for eligible dependents. **If you obtain coverage for a person who is not eligible, you will have to pay federal and state tax on the fair market value of benefits provided to that individual.**

Eligible dependents generally include: your legally married spouse or civil union partner and eligible children until age 26 for medical and age 19 for dental. Your "children" include your natural children, stepchildren, and adopted children. Children for whom you are the legal guardian may be eligible for coverage up to age 18 unless proof of continued dependency is provided. Disabled children may be covered beyond age 26.

Please refer to the Comptroller's website at www.osc.ct.gov for details about dependent eligibility.

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

Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes during the plan year (July 1 – June 30) unless you experience a qualifying status change. If you do have a qualifying status change, you must notify the Retirement Health Insurance Unit **within 31 days of the event.** The change you make must be consistent with your change in status.

Please call the Retirement Health Insurance Unit if you experience a qualifying status change – which include changes in:

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

If you experience a change in your life that affects your benefits, contact the Retirement Health Insurance Unit at (860) 702-3533. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).

Health Enhancement Program

The Health Enhancement Program (HEP) has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your health care. Third, it will save money for the state long term by focusing our health care dollars on prevention. It's your choice whether or not to participate, but there are many advantages to doing so.

HEP encourages retirees and enrolled family members to take charge of their health and health care by following health guidelines defined by the Program.

You Save Money by Participating!

When you and all of your enrolled family members participate in HEP, 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 may also receive a $100 payment, provided you and all enrolled family members comply with HEP requirements. You also save money on prescription drugs to treat that condition (see page 6).

If You Do Not Enroll in HEP

Unless you enroll in HEP, 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.

How to Enroll in HEP

Current Retirees:

For those who are not currently participating in HEP, you can enroll during open enrollment. Forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533.

Those who participated in HEP during 2012-2013 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2013-2014 and will continue to pay lower premiums for their health care coverage.

New Retirees:

If you are a new retiree, you must complete the HEP enrollment form upon making your benefit elections. HEP enrollment forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533. If you do not wish to continue participation in HEP, you can disenroll during open enrollment.

Health Enhancement Program Requirements

You and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams).

For calendar year 2013 you must complete at least one dental cleaning. All of the plans cover up to two cleanings per year (HEP enrollees are covered 100% for these cleanings). Periodontal maintenance is not subject to an annual maximum for HEP participants; however, cost shares and frequency limits may still apply. See page 22 for additional information.

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 will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy co-pays for treatments related to your condition (see Your Prescription Drug Coverage at a Glance on page 8 for cost details).

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

New HEP Administrator and Website

ConneCT 2yourhealth
Care Management Solutions – a ConnectiCare affiliate

care management solutions
a ConnectiCare affiliate

Care Management Solutions, an affiliate of ConnectiCare, is the new administrator for the Health Enhancement Program (HEP). The HEP participant portal has new features to help you manage your health and your HEP requirements. You can visit www.cthep.com to:

- View HEP requirements and download HEP forms
- Check your HEP compliance status
- 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 Mangement Solutions
www.cthep.com
(877) 687-1448 Monday – Friday, 8:00 a.m. – 5:00 p.m.

An online tutorial has been created to provide information about the new site and help you with registering. Visit www.cthep.com and click on the hyperlink to your right.

Visit www.cthep.com to Create a New Account

All HEP enrollees, spouses, and dependents age 18 and over need to create a new online account the first time they visit www.cthep.com (even if you already participate in HEP and had an account on the old website).

Check Your Status

You have until December 31, 2013 to complete your 2013 HEP requirements. However, now is a great time to check your status and confirm which requirements you still need to complete.

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
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$15 co-pay		80%[1]
Preventive Care	No co-payment for preventive care visits and immunizations		80%[1]
Emergency Care	$35 co-pay[2]		$35 co-pay
Diagnostic X-Ray and Lab	100% (prior authorization required for diagnostic imaging)		80%[1] (prior authorization required for diagnostic imaging)
Pre-Admission Testing	100%		80%[1]
Inpatient Physician	100% (prior authorization required)		80%[1] (prior authorization required)
Inpatient Hospital	100% (prior authorization required)		80%[1] (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)		80%[1] (prior authorization required)
Ambulance	100% (if emergency)		100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%		80%,[1] up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	$15 co-pay, 1 exam per year[3]		50%, 1 exam per year
Audiological Screening	$15 co-pay, 1 exam per year		80%,[1] 1 exam per year
Mental Health/Substance Abuse	Prior authorization required		Prior authorization required
Inpatient	100%		80%[1]
Outpatient	$15 co-pay (prior authorization may be required)		80%[1] (prior authorization may be required)
Durable Medical Equipment	100% (prior authorization may be required)		80%[1] (prior authorization may be required)
Prosthetics	100% (prior authorization may be required)		80%[1] (prior authorization may be required)
Skilled Nursing Facility	100% (prior authorization required)		80%,[1] up to 60 days/year (prior authorization required)
Home Health Care	100% (prior authorization may be required)		80%,[1] up to 200 visits/year (prior authorization may be required)
Hospice	100% (prior authorization required)		80%,[1] up to 60 days (prior authorization required)
Annual Deductible	Individual: $350[4] Family: $350 each member[4] ($1,400 maximum)		Individual: $300 Family: $900
Annual Out-of-Pocket Maximums	Individual: $350[4] Family: $350 each member[4] ($1,400 maximum)		Individual: $2,000 (plus deductible) Family: $4,000 (plus deductible)
Lifetime Maximum	None		None
Pre-admission Authorization/ Concurrent Review	Through participating provider		Penalty of 20% up to $500 for no authorization

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

[2] Waived if admitted.

[3] HEP participants have $15 co-pay waived once every two years.

[4] Waived for HEP-compliant members.

Your Prescription Drug Coverage at a Glance

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by Silverscript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

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

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose.

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

NON-MEDICARE ELIGIBLE

CVS/Caremark	**In-Network**			**Out-of-Network**
	Acute Drugs	**Maintenance Drugs***	**HEP Enrolled** (Maintenance Drugs to treat chronic condition)*	
Generic	$5	$5	$0	20% of prescription cost
Preferred Brand	$20	$10	$5	20% of prescription cost
Non-Preferred Brand	$35	$25	$12.50	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance drugs.

MEDICARE-ELIGIBLE

Silverscript	**In-Network**			**Out-of-Network**
	Acute Drugs	**Maintenance Drugs***	**HEP Enrolled** (Maintenance Drugs to treat chronic condition)	
Generic	$5	$5	$0	20% of prescription cost
Preferred Brand	$20	$10	$5	20% of prescription cost
Non-Preferred Brand	$35	$25	$12.50	20% of prescription cost

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.

When You Become Eligible for Medicare

If you are eligible for Medicare, you will be automatically enrolled in the SilverScript program. Your prescription benefits are the same but you use your SilverScript ID card for prescriptions instead.

When you are enrolled, you will receive more information. However, there are four key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- When you receive a letter from SilverScript giving you the chance to opt out or cancel your enrollment, don't do it. They are required to send you this letter but if you opt out, medical and prescription drug coverage for you and your dependents will terminate. You can just ignore it.
- If you receive a notice that you are required to pay a higher Medicare D premium, you must submit that notice to the Retirement Health Insurance Unit for reimbursement.
- If you receive your mail at a post office box, you must provide a street address to the Retirement Health Insurance Unit per Center for Medicare and Medicaid Services regulations.
- Do not enroll in an individual Medicare Part D prescription drug plan. Doing so would cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted on previous page, if you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

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

Non-Medicare Retirees Mandatory 90-Day Refills

If you are not enrolled in Medicare, 90-day refills are mandatory for maintenance medications. However, you do not have to use mail order. The initial 30-day supply can be filled at any participating pharmacy. After that, you can fill your medication at a pharmacy that participates in the state's Maintenance Drug Network, or use Caremark's mail order service. A link to the complete list of pharmacies in the Network can be found on the Office of the State Comptroller's website at www.osc.ct.gov.

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, Cleanings, and X-rays	Covered at 80%*	Covered at 100%* (network only)	Covered at 100%
Simple Restoration Fillings	Covered at 80%	Covered at 80%	Covered**
Oral Surgery	Covered at 67%	Covered at 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: 100% coverage for cleanings and exams (2 per year). (Use network dentists under Enhanced plan for 100% coverage.) No annual maximum on services for periodontal maintenance (2 per year) or scaling and root planing (frequency limits and cost shares may still apply).

** 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. However, your out-of-pocket expenses may be higher if you see an out-of-network provider.

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, 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 28.)

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

Your 2013-2014 Premium Share

Monthly Medical Premiums July 1, 2013 through June 30, 2014

Medical plan options with no retiree premium share:

Point of Enrollment – Gatekeeper Plans

Anthem State BlueCare POE Plus
UnitedHealthcare Oxford HMO

Point of Enrollment Plans

Anthem State BlueCare POE
UnitedHealthcare Oxford HMO Select

Out-of-Area Plans

UnitedHealthcare Oxford USA Out of Area plan
Anthem Out-of-Area plan

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS	ANTHEM PREFERRED Closed to New Enrollment
1 Person on Medicare	$0.00	$0.00	$0.00
1 Person not on Medicare	$11.48	$11.82	$11.28
1 Person not on Medicare and 1 on Medicare	$11.48	$11.82	$11.28
1 not on Medicare and 2 on Medicare	$11.48	$11.82	$11.28
2 on Medicare	$0.00	$0.00	$0.00
2 not on Medicare	$25.26	$26.00	$24.81
2 not on Medicare and 1 on Medicare	$25.26	$26.00	$24.88
3 or more on Medicare	$0.00	$0.00	$0.00
3 or more not on Medicare	$31.00	$31.91	$30.44
3 or more not on Medicare and 1 on Medicare	$31.00	$31.91	$30.48

Dental Premiums July 1, 2013 through June 30, 2014

COVERAGE LEVEL	United Basic	United Enhanced	CIGNA DHMO
1 Person	$31.23	$28.73	$29.95
2 Persons	$62.46	$57.46	$65.89
3 or More Persons	$62.46	$57.46	$80.87

Important Note: Higher Premiums Without HEP

If your retirement date is October 2, 2011 or later you are eligible for the Health Enhancement Program (HEP). If you choose not to enroll, or enroll but do not meet the HEP requirements, your monthly premium share will be $100 higher than shown above.

If you would like to change your HEP enrollment status, you may complete a form. Forms are available at www.osc.ct.gov or from the Retirement Health Insurance Unit at (860) 702-3533.

If You Retired Early

If you retired early, you may pay additional retiree premium share costs per the 2011 SEBAC agreement. For additional information, please contact the Retirement Health Insurance Unit at (860) 702-3533.

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. Yet, your premium share varies quite a bit from plan to plan. How do you decide?

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

1. **What is covered** – the services and supplies that are covered 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 7).
2. **Cost** – what you pay when you receive medical care and what is deducted from your pension check. What you pay at the time you receive services is similar across the plans (see page 7). However, your premium share varies quite a bit (see page 11).
3. **Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 13 and 14).
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 13 – 24).

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 first retired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs. Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same healthcare services?

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

Why Networks Matter

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

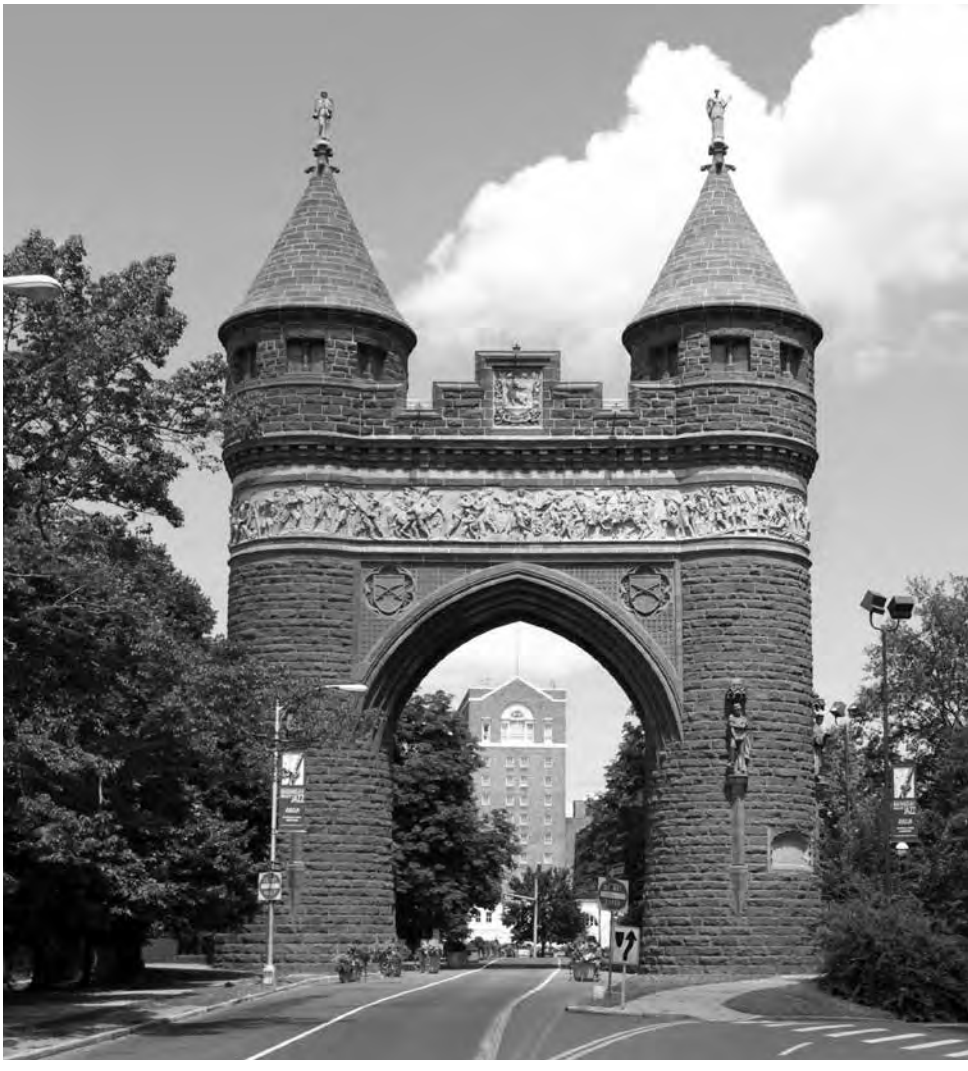
- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care –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

Is a National Network Important to You?

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

- Planning to live or travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that's not in Connecticut or the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. 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 health care services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

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

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

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 prior authorization requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require prior authorization (see page 7), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live or Work Affects Your Choices

You must live or work within a plan's regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the 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 health care services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency), some give you access to out-of-network providers when you pay more of the fees, some require you to select a PCP.
- **Health promotion** – Remember, there's more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.
- **Provider networks** – You'll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 28 for phone numbers and websites.)

About Value-Added Programs

Another area where the insurance carriers may differ is the value-added programs they offer. These programs are outside the contracted plan benefits – they're "extras" that each company offers in hopes of making their plan stand out, such as:

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

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

	POINT OF ENROLLMENT – GATEKEEPER (POE-G) PLANS		POINT OF ENROLLMENT (POE) PLANS		POINT OF SERVICE (POS) PLANS			OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford 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.

Comparing Plans: A Message From Anthem

Your Plan Options From Anthem

	State BlueCare POE Plus In Network	State BlueCare POE In Network	State BlueCare POS In/Out-of-Network	Anthem Out of Area Plan
Office Visit Co-pay	$15*	$15*	$15*	$15*
Specialist Co-pay	$15*	$15*	$15*	$15*
Specialist Referral	Yes	No	No	No
Local & National Provider Networks	Yes	Yes	Yes	Yes
Hospital Network	Local and national	Local and national	Local and national	Local and national
National Access	Yes	Yes	Yes	Yes
International Access	Yes	Yes	Yes	Yes

* Retiree co-pays may vary

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.

Service: putting your health first

We've been in Connecticut for more than 75 years, and we've been serving State of Connecticut employees and retirees for more than 50 of those years. This means we know your needs, and we're ready and able to help. Get answers and information through our:

- **State-dedicated Member Services Unit at 800-922-2232:** Talk with a customer service expert who is located right here in the state and is dedicated solely to State employees and retirees.
- **State-dedicated website at anthem.com/statect:** Find information geared specifically to you and other State employees and retirees.

24/7 NurseLine

You can call the toll-free number — **800-711-5947** — to talk with a nurse about your general health questions any time of the day or night. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. Our nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do.

You can also listen to recorded messages on hundreds of health topics. Just call the 24/7 NurseLine number and choose the Audio-Health Library option.

Wellness: making your health a top priority

Lose weight. Join a gym. Control asthma. When it comes to our health, we all have different goals. That's why we have a full range of wellness programs, online tools and resources designed to meet your unique needs.

[1] *Anthem Health and Wellness Program Satisfaction Study.*

SpecialOffers@Anthem is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers@Anthem vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers@Anthem program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

Service. Wellness. Better health.

Customer service that's focused on your needs. Wellness programs that support and guide you. Plans that promote better health. Your health care plan should fit into your personal plan.

Anthem's Health and Wellness

From finding an answer to a common health question to getting one-on-one support for a chronic health condition, you can get the help you need through our Anthem Health and Wellness program. Learn more at anthem.com/statect.

SpecialOffers@Anthem℠

As a State employee or retiree, you can get discounts on products that encourage a healthy lifestyle. You'll get "healthy discounts" on things like:

- Weight loss programs through Weight Watchers®, Jenny Craig® and more
- Fitness club memberships, equipment and coaching
- Hearing aids
- Allergy products
- Acupuncture
- Massage therapy
- Baby safe gear
- Senior Care services

A health plan that gives you more health

Your health plan should do more than just help you when you're sick. It should help you be your healthiest. That's why Anthem plans include things like vision benefits and large nationwide networks. So you can get more health from your health care.

Vision

The Anthem plans for the State of Connecticut include vision coverage and discounts:

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

- **1-800 CONTACTS** — Get contact lenses quick and easy — plus discounts only available to Anthem members, like $20 off when you spend $100 or more, and free shipping.
- **Glasses.com** — Try on any five of the 1,500 designer frames — at home, for free — before you buy. It's convenient, plus you get exclusive member savings like $20 off when you spend $100 or more, and free shipping and free returns.
- **Premier LASIK** — Save 15% on LASIK with all their in-network providers and prices as low as $695 per eye with select providers. Network access.

Have a question? Call our State-dedicated Member Services Unit at 800-922-2232. We're ready to help you. You'll also find good information at anthem.com/statect.

Network access

Anthem provides expansive coverage nationally and around the world. Through the BlueCard® program, you can use the networks of other Blue Cross and Blue Shield plans, so you can get the care you need — just about anywhere you travel. We can help you find the right care locations outside of Connecticut by calling 800-810-BLUE.

Comparing Plans: A Message From UnitedHealthcare

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.

Now is the Time to Live Well.

Five Reasons UnitedHealthcare is the right decision for you and your family:

1: Cost Savings

Choosing an Oxford plan from UnitedHealthcare can save you premium dollars all year. You can save even more through our Healthy Bonus member discounts that give you access to discounts and special offers on products and services that can help you make the best kind of investment: a healthy lifestyle.

2: Network

A robust national and local network means your doctor likely already participates with your plan. State of Connecticut employees and retirees have access to all hospitals in Connecticut.

3: Medical and Dental Coverage

You may have our dental coverage, but we offer medical too. Be sure to take a look at the medical plans offered by UnitedHealthcare. For more information on our money-saving medical plans, visit welcometouhc.com/stateofct.

4: Trust

You should trust that you are making a great decision choosing UnitedHealthcare. You need to choose someone you can depend on and with an Oxford Health Plan from UnitedHealthcare you come first. We are committed to helping people live healthier lives.

5: Tools and Resources

Everything you need at your fingertips, 24/7. Search for a doctor, view your claims, online health coaching and much more.

Our Network

All medical plans offer access to our local and national network

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

For more information about our network or to search for physicians participating in our local and UnitedHealthcare Choice Plus Network, please visit welcometouhc.com/stateofct.

UnitedHealth Premium® Program

UnitedHealth Premium puts quality and cost efficiency information about area physicians and facilities in your hands. Just look for the stars on myuhc.com®.

UnitedHealth Premium® Designation Program

Don't leave your health care choice to chance.

UnitedHealth Premium helps you find the doctor or facility that is right for you

It can be difficult to choose a doctor from just a list of names.

We've done the homework for you

This program identifies doctors and facilities that meet quality criteria using evidence-based medical standards, clinical guidelines, and expert physician advice.

How the program works: Just look for the stars

Doctors and facilities in our network are evaluated on two levels:

★ *Quality*

One star means a physician or facility has met quality of care guidelines by following national evidence-based medical standards and practices.

★★ *Quality and cost efficiency*

Two stars mean a physician or facility has met the criteria for quality of care based on national medical standards and practices, and for cost efficiency.

Easy online access

How do you find a UnitedHealth Premium-designated doctor or facility? The UnitedHealth Premium designation program delivers the results to you at myuhc.com®. Just look for the stars next to your search results. We have evaluated doctors in 21 specialties, as well as cardiac care, congenital heart disease, spine surgery, total joint, infertility, and neonatology facilities.

Oxford On-Call®

Healthcare Guidance 24 hours a day

We realize that questions about your health can come up at any time. That's why we offer you flexible choices in health care guidance through our *Oxford On-Call®* program. Speak with a registered nurse who can offer suggestions and guide you to the most appropriate source of care, chat online with a nurse about your general health questions or listen to recorded messages on over 1,100 health topics – 24 hours a day, seven days a week. That's the idea behind *Oxford On-Call.*

If you are a member and you need to reach Oxford On-Call, please call 800-201-4911. Press option 4. Oxford On-Call can give you helpful information about many topics such as:

General Health Information

Oxford On-Call can give you helpful information about many topics. Call about illness, injury, chronic conditions, prevention, healthy living, and men's, women's and children's health.

Deciding Where to Go for Care

Not sure if your situation calls for a doctor visit? Wonder if you should go to an after-hours urgent care clinic or the emergency room? *Oxford On-Call's* nurses provide information that can help you choose care that is appropriate for your situation.

Choosing Self-Care Measures

Registered nurses provide practical self-care tips to help you manage your condition at home. Nurses can also tell you about signs and symptoms that may indicate the need for a higher level of care.

Communicating With Your Healthcare Provider

Make the most of your doctor visits. Call *Oxford On-Call* before you go to your appointment, and a nurse can help you make a list of questions to ask your doctor.

Guidance for Difficult Decisions

If you or a family member has a serious medical condition, *Oxford On-Call* nurses can be a great resource. Learn more about medical conditions, the possible risks and benefits of treatment options and information to help you take medications safely. The more you know, the better prepared you'll be.

Health Information Library

Listen to more than 1,100 recorded messages on health and well-being topics. To access the library, call the *Oxford On-Call* phone number and choose the option for Health Information Library. Enter PIN number 123. You can ask a nurse about the topics and code numbers.

Live Web Chat

Nurses are available to chat online about a variety of health topics and to confidentially guide you to online resources.

Healthy Bonus® Member Discounts

We understand that rising health care costs nationwide affect our members. We strive to help you stretch your health care dollar by developing programs that aim to help you improve your health.

We recognize there are ways we can help members reduce out-of-pocket health care costs. We believe in the power of prevention: that by taking a little extra time to eat better, exercise and reduce stress, individuals can do a better job of staying on the path of wellness.

Our *Healthy Bonus* program offers access to discounts and special offers on products and services that can help you make the best kind of investment: a healthy lifestyle. Please visit welcometouhc.com/stateofct to obtain information on the discounts offered to you on things like fitness/fitness equipment, diabetes/disease management, keeping kids healthy and overall wellness.

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 28.

If I live outside Connecticut, do I need to choose an Out-of-Area Plan?

Not necessarily. You may live outside Connecticut but still within a carrier's regional service area. If you live outside any of the plans' regional service areas, you may choose from one of the Out-of-Area plans. Contact Anthem and/or UnitedHealthcare Oxford to find out which plans offer providers in your area.

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.

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

Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 28. 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 July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 4). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

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.

Comparing Your Plans: A Message From UnitedHealthcare Dental

UnitedHealthcare®

Overview of UnitedHealthcare Dental® benefits

Now is the Time to Live Well

Better oral health can lead to better overall health. At UnitedHealthcare, we know that the health of your teeth and gums is linked to better health overall. By brushing and flossing carefully and visiting the dentist for regular checkups, you can enjoy a healthier mouth, which plays a key role in your overall health and well-being.

How do I know which plan is best for me?

We realize that one plan does not fit all so we've created two plans to choose from: the Enhanced Plan and the Basic Plan. With both plans you have access to in- and out-of-network dentists. **However, you may have lower out-of-pocket costs when you visit a participating network dentist. To learn more, compare the options below.**

Basic Plan

- You can visit any dentist or dental specialist, without a referral
- Preventive services covered at 80%, including oral cancer screening
- HEP enrollees covered at 100% for 2 cleanings per year
- No deductibles

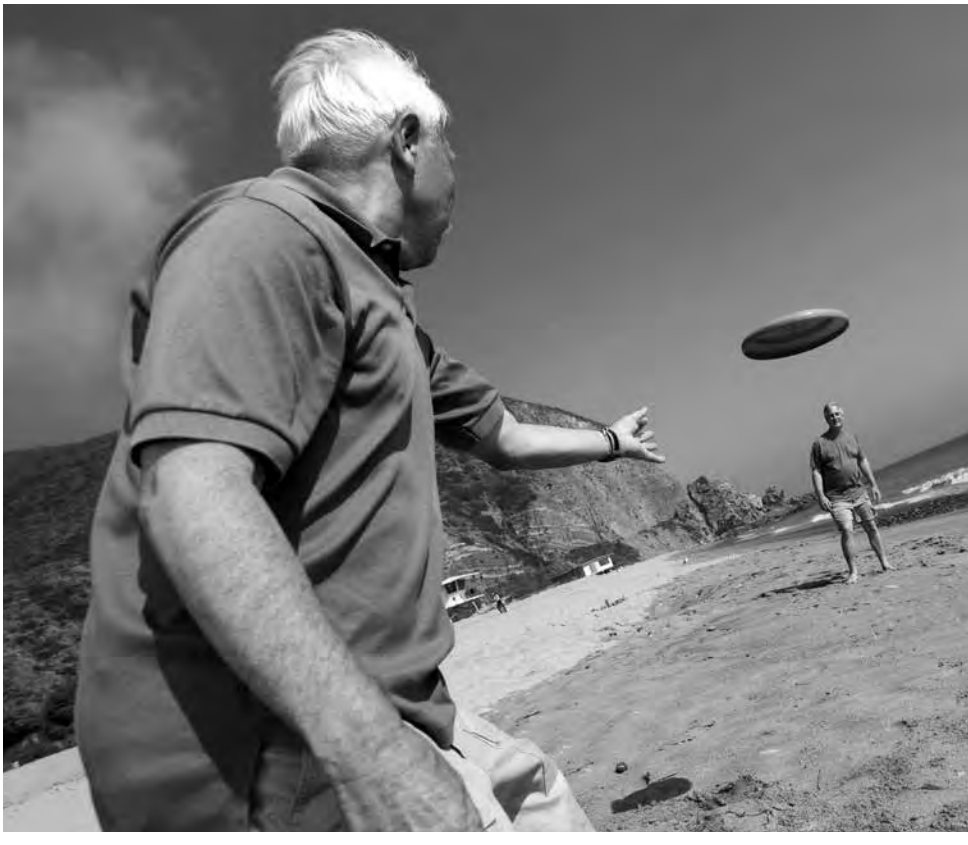
Enhanced Plan

- Flexibility to seek care outside of the network with higher out-of-pocket member costs. Non-network payments are paid at the maximum allowable charge (MAC)
- Realize cost savings per procedure by utilizing a network dentist or specialist
- All preventive services covered at 100% in network, including oral cancer screening
- Coverage for orthodontics, bridges and dentures for adults and children
- No referral needed

If you have any questions, call customer service at **800-896-4834** or visit **www.myuhcdental.com/statect.**

† For indemnity plans or PPO plans with out-of-network options, fees are set to maximum allowable charges.

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.



Comparing the Basic and Enhanced Plans

UnitedHealthcare offers State of Connecticut members and retirees two dental plans: UnitedHealthcare Dental® Enhanced Plan or UnitedHealthcare Dental® Basic Plan.

			ENHANCED DENTAL PLAN			
	Basic Dental Plan	**Basic Dental Plan with HEP**	**Network**	**Network with HEP**	**Out-of-Network**	**Out-of-Network with HEP**
Calendar year deductible (waived for preventive and diagnostic); does not apply to orthodontics	Not applicable	Not applicable	$25 individual/ $75 family		$25 individual/ $75 family	
Calendar year maximum (combined for network and out-of-network); does not apply to orthodontics	Not applicable	Not applicable	$3,000		$3,000	
Periodontics annual maximum	$500 per calendar year	Annual maximum waived for certain periodontal procedures	Included with calendar year maximum **waived on certain procedures for HEP enrollees**		Included with calendar year maximum **waived on certain procedures for HEP enrollees**	
Cleanings	80%	100%	100% network only	100% network only	100% of MAC	100% of MAC
Sealants	Not covered	Not covered	100% network only	100% network only	100% of MAC	100% of MAC
Orthodontics lifetime maximum (combined for network and out-of-network)	Not applicable	Not applicable	$1,500		$1,500	
Consumer MaxMultiplier℠	Not applicable	Not applicable	Yes		Yes	
Prenatal Dental	Yes	Yes	Yes		Yes	

IMPORTANT INFORMATION TO KNOW ABOUT YOUR HEP BENEFITS

- Full coverage for cleanings and exams (2 per year) and bitewing x-rays (1 per year) under the Basic and Enhanced plans. **Note: Under the Enhanced plan you must use an in network dentist to receive 100% coverage.**
- No annual maximum on services for periodontal maintenance (2 per year) or scaling and root planing (frequency limits and applicable cost shares still apply).

Comparing Your Plans: A Message From Cigna

Are you looking for a dental plan with the following features?

- **NO** deductibles and **NO** annual dollar maximums
- Orthodontia coverage for children *and* adults
- Teeth whitening coverage

If so, then the **Cigna Dental Care® (DHMO)** plan may be the best option for you and your family.

Visit our website designed specifically for State of CT employees at **http://www.cigna.com/stateofct**

DHMO Basics

When you sign up for the DHMO plan, you select a primary network general dentist, who will handle all of your dental care needs.

You then receive a Patient Charge Schedule, or "PCS," that lists the specific dental procedures covered by the plan and the amount you would pay the dentist (your copays). These copays are fees that apply only when you receive treatment from the dentists or dental specialists in our large DHMO Network. If a dental procedure is not listed on your PCS, it is not covered and you will have to pay according to the dentist's regular fees.

It's important to remember that selecting a primary network general dentist is required before receiving care with the DHMO.

Benefits of Saying "No" with the DHMO

Highlights of the Cigna DHMO include:

- **NO** charges for most preventive services such as exams, x-rays and routine cleanings
- **NO** deductibles to pay before you can use your plan
- **NO** annual dollar maximums to limit your benefits
- **NO** claim forms to file
- **NO** referrals required for children under seven to visit a network pediatric dentist
- **NO** referrals required to receive care from a network orthodontist
- **NO** age limit on sealants, which help prevent tooth decay
- **NO** additional charge for second opinions
- **NO** ID cards required to receive care

Lower Premiums

Please review page 11 of this booklet to see how much you could save per month by enrolling in the Cigna DHMO.

Enhanced Coverage through Cigna Oral Health Integration Program

Eligible State of Connecticut employees who enroll in the Cigna DHMO plan will have access to enhanced dental coverage through the **Cigna Dental Oral Health Integration Program® (OHIP).**

With this program, eligible participants with certain medical conditions may receive 100% reimbursement of their copays for select covered dental services.

The qualifying medical conditions for the program include:

- Heart disease
- Stroke
- Diabetes
- Head & neck cancer radiation
- Maternity
- Chronic kidney disease
- Organ transplants

Periodontal treatment and maintenance (procedures D4341, D4342 and D4910) is one service that qualifies for reimbursement for all of the medical conditions listed above. Other dental services are tied to specific medical conditions.

For additional information regarding OHIP, please visit **http://www.cigna.com/stateofct** – the website developed by Cigna just for State of CT employees.

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.

Orthodontia Coverage

A key feature of the Cigna DHMO is that the plan offers orthodontia coverage for children *and* adults. Please refer to your PCS for the exact orthodontia procedures covered under the Cigna DHMO plan.

Below are out-of-pocket costs to think about when it comes to 24-month comprehensive orthodontia coverage for children. Please note that the Cigna copay amount and length of treatment may vary based on the individual situation.

Average cost in CT	$6,397.00
Cigna copay amount	**$3,139.00**

Finding a DHMO Dentist is Easy

For the most current information on network dental offices in your area, search our online directory at **www.Cigna.com/stateofct** or call the Dental Office Locator at **1.800.Cigna24 (1.800.244.6224).**

Important Note: UConn Health Center is part of the Cigna DHMO Network.

Cigna and the Health Enhancement Program (HEP)

If enrolled in the HEP, remember to get your required annual preventive care cleanings.

Review your enrollment kit materials carefully before you enroll

If you have more questions, visit us online at **www.Cigna.com/stateofct** or call us for LIVE assistance 24/7 at **1.800.Cigna24 (1.800.244.6224).**

Once you are enrolled in the Cigna DHMO

Register for our secure, easy-to-use web site, **myCigna.com/stateofct**, and get the tools to review your dental plan information, find a network dentist, and much more!

Still Undecided About Your Dental Plan?

If so, then take a look at the questions below. Your answers may help you decide which plan is the best fit for you and your family.

For each question below, check either "Yes" or "No"		
Do you prefer a plan that tells you the **exact dollar** amount you will pay for each procedure, so you don't have to calculate percentages?	❑ Yes	❑ No
Do you prefer a dental plan that has **no annual dollar maximums,** so you don't have to worry about your benefits running out if you reach a certain amount?	❑ Yes	❑ No
Do you prefer a dental plan with **no deductibles,** so your benefits kick in right away, rather than waiting to reach a certain level of out-of-pocket expenses first?	❑ Yes	❑ No
Would you change dentists if it meant **spending less** out-of-pocket for your dental care costs?	❑ Yes	❑ No
Would you be willing to select a **primary care network dentist** to manage all your dental care needs?	❑ Yes	❑ No

If you have more "Yes" checks than "No" checks, the Cigna DHMO may be the best plan for you.

Retirement Health Insurance
Open Enrollment Application

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775
www.osc.ct.gov

TYPE OR PRINT AND FORWARD TO THE RETIREMENT SERVICES DIVISION

INSURANCE IS EFFECTIVE THE FIRST OF THE MONTH FOLLOWING THE RETIREMENT DATE

RETIREE NAME (Person Receiving Benefit) (Last Name, First Name, MI)	RETIREMENT DATE	EMPLOYEE NUMBER (From Active Employment)

MAILING ADDRESS	TELEPHONE NUMBER

YOUR OPTIONS

This statement lists your benefit options. Use this page to select your medical and dental coverage. Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records. Please be aware that you and any dependents who enroll in medical coverage must also enroll in prescription coverage and that prescription coverage is not available to individuals who are not enrolled in a medical plan.

Check the box to the left of the plan you wish to select.

MEDICAL

ANTHEM

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

OXFORD

- ☐ Oxford Freedom Select POS
- ☐ Oxford HMO Select POE
- ☐ Oxford HMO POE-G
- ☐ Oxford USA - Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**

DENTAL

☐ CIGNA Dental DHMO ☐ United Basic Dental ☐ United Enhanced Dental PPO

RETIREE/DEPENDENTS

List you and all of your dependents to be enrolled in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

NAME	RELATIONSHIP (i.e., Spouse, Son, Daughter)	GENDER F	GENDER M	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAL & PRESCRIPTION	DENTAL
	Retiree	☐	☐			☐	☐
	Dependent 1:	☐	☐			☐	☐
	Dependent 2:	☐	☐			☐	☐
	Dependent 3:	☐	☐			☐	☐

COORDINATION OF BENEFITS – APPLICATION IS INVALID UNLESS THIS SECTION IS COMPLETED

When you are covered by the Health Plan Selected will you or your dependent(s) have any other coverage? ☐ Yes ☐ No

If yes, which family member(s) will be covered by that insurance? (Check off as many that apply)

☐ Self ☐ Spouse ☐ Children (List Names):

NAME OF PLAN	ADDRESS
POLICY NUMBER	NAME OF PERSON(S) POLICY ISSUED TO
EFFECTIVE DATE	COMPANY THROUGH WHICH COVERAGE OBTAINED

Is any member listed above eligible for Medicare? ☐ Yes ☐ No

If yes give Medicare Part A (Hospital Insurance) and Medicare B (Medical Insurance) effective date(s):

RETIREE		Dependent 1		Dependent 2		Dependent 3	
PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s). I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE

Forms must be postmarked by June 7, 2013.

To enroll or make changes, clip out this form,
complete it and return it to:

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

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Your Benefit Resources

For details about specific plan benefits and network providers, contact:

Health Enhancement Program (HEP) Care Management Solutions (an affiliate of ConnectiCare)	**www.cthep.com**	**1-877-687-1448**
Anthem Blue Cross and Blue Shield • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area	**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.welcometouhc.com/stateofct**	**1-800-385-9055** Call 1-800-760-4566 for questions before you enroll
Caremark (Prescription drug benefits, any medical plan, non-Medicare eligible)	**www.Caremark.com**	**1-800-318-2572**
SilverScript (Prescription drug benefits, any medical plan, Medicare eligible)	**http://stateofconnecticut.silverscript.com**	**1-866-693-4624**
UnitedHealthcare (Dental) • Basic Plan • Enhanced PPO	**www.Myuhcdental.com/statect**	**1-800-896-4834**
CIGNA • DHMO Plan	**www.Cigna.com/stateofct**	**1-800-244-6224**

For information about eligibility, enrolling in the plans, making changes to your coverage, or premium share amounts, contact:

Office of the State Comptroller Retirement Health Insurance Unit 55 Elm Street Hartford, CT 06106-1775	**www.osc.ct.gov**	**(860) 702-3533**

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