Adjunct Faculty
Insurance Rates July 1, 2016 – June 30, 2017
Monthly Rates

Adjunct faculty may purchase medical and/or dental insurance at their own expense. If interested, you must enroll within 31 days of the semester begin date or the date your adjunct contract is generated, whichever is later. Please contact the Human Resources department at 203-837-8497 to enroll. Adjunct faculty must be employed by the University to remain on insurance coverage. If you are not teaching in the summer, the insurance coverage will be terminated and a COBRA notice will be issued. Once enrolled, employee directed cancellation of coverage is only allowed during the annual Open Enrollment period or through a properly documented qualifying event. Adjunct faculty will be billed monthly for the cost of their insurance. Employees enrolling dependents on their coverage, must provide relationship documentation. Please read Attachment A.

In some circumstances, adjunct faculty may be eligible for reimbursement for their medical and/or dental premiums, up to the cost of the State sponsored insurance rates. Adjuncts who qualify for the State sponsored health insurance and who fail to pay their premium by the due date, will result in the forfeiture of the State reimbursement for the entire semester. Please read the attached document for more information.

	Employee	Employee + One	Family
MEDICAL			
Anthem Blue Cross and Blue Shield			
Anthem State BlueCare (POS)	$809.74	$1,781.43	$2,186.30
Anthem State BlueCare (POE)	$785.65	$1,728.43	$2,121.25
Anthem State BlueCare Plus (POE-G)	$783.05	$1,722.71	$2,114.23
Anthem Out of Area	$1,105.33	$2,431.73	$2,984.39
UnitedHealthcare (Oxford)			
Oxford Freedom Select (POS)	$662.28	$1,457.02	$1,788.16
Oxford HMO Select (POE)	$632.21	$1,390.86	$1,706.97
Oxford HOM (POE-G)	$583.45	$1,283.59	$1,575.32
Oxford Out of Area	$701.54	$1,543.39	$1,894.16
DENTAL			
Cigna			
Basic Plan	$51.58	$157.32	$157.32
Enhanced Plan	$44.45	$135.57	$135.57
DHMO Plan	$27.95	$61.49	$75.46

Effective 1/5/2011 (rev. 2/20/2015)

APPENDIX A

Documentation Requirements for Enrollment of Dependents for Health Benefits

The following documentation must be submitted with the enrollment form for health insurance benefits at the time the employee applies for coverage:

RELATIONSHIP	DOCUMENTATION REQUIRED
Spouse	Marriage Certificate or Connecticut-issued Civil Union Certificate*
Party to a Civil Union	Civil Union Certificate (issued by a state other than Connecticut)
Dependent Child Under Age 26 - Employee is birth parent - Employee is Legal Guardian - Employee is adoptive parent - Employee is Step Parent	 - Long Form Birth Certificate - Documentation of Legal Guardianship** - Notification of Placement for Adoption from the adoption agency or a certified copy of the Adoption Decree - Long Form Birth Certificate and Marriage Certificate
Disabled Child - Over Age 26 (Medical) - Over Age 19 (Dental)	Requires documentation noted above (if not already on file) and completion of the insurance carrier's medical verification form

If an eligible dependent is being added after initial enrollment but outside of the open enrollment period due to loss of other health insurance coverage, the employee must submit appropriate documentation of the relationship as noted above and official notification of the loss of coverage (COBRA notification or notice from employer of loss of benefits).

Employees changing plans during open enrollment without adding a new dependent will not have to submit additional proof of relationship for dependents covered under the old plan.

* A Marriage Certificate must be provided when enrolling a spouse. A Connecticut-issued Civil Union Certificate is only acceptable for those who entered into a Civil Union at a time prior to the legalization of same sex marriage in Connecticut.

** Proof of Guardianship or Custody from a court of competent jurisdiction. A custody agreement from another state will not be honored unless it has been approved by a State of Connecticut Court or the State of Connecticut Department of Children and Families. The minor child must reside with the Covered Employee to be eligible for coverage under the plan.

IMPORTANT INFORMATION FOR PART-TIME FACULTY REGARDING ELIGIBLITY FOR HEALTH INSURANCE

August, 2007

- **Effective with the fall, 2007 semester, part-time faculty are eligible for state sponsored health insurance.**

- **Eligibility for health insurance under CGS Section 5-259c means teaching nine (9) or more credits in the aggregate, per semester, at multiple locations within any of the State of Connecticut university or college systems: Connecticut State University System (CCSU, ECSU, SCSU, WCSU); University of Connecticut; or any of the community colleges.**

- **Eligible faculty will be required to pay the entire cost of the premium for such coverage.**

- **Eligible faculty will be reimbursed for the state share of the health insurance premium *after the semester ends.***

- **Eligible faculty will be *billed* for the premiums. Payroll deduction is not available. Bills must be paid on time. Failure to do so will result in the forfeiture of the entire reimbursement for that semester.**

- **Reimbursement is for whole months only, and for spring and fall semesters only (no intersession or summer session).**

- **The eligible faculty member's active primary job (as listed in the State's HR Information System) will be used to determine effective dates.**

- **For example, if the hire date is August 31 and the termination date is December 15, the State share reimbursement is for October, November, and December.**

- **After January 2008, faculty receiving reimbursement in consecutive fall and spring semesters will be eligible for coverage on the first day of the first month immediately following the hire date. For example, if the hire date is January 15 and the termination date is May 15, coverage is effective during the months of February, March, April and May. The State share reimbursement will be for these four months as well.**

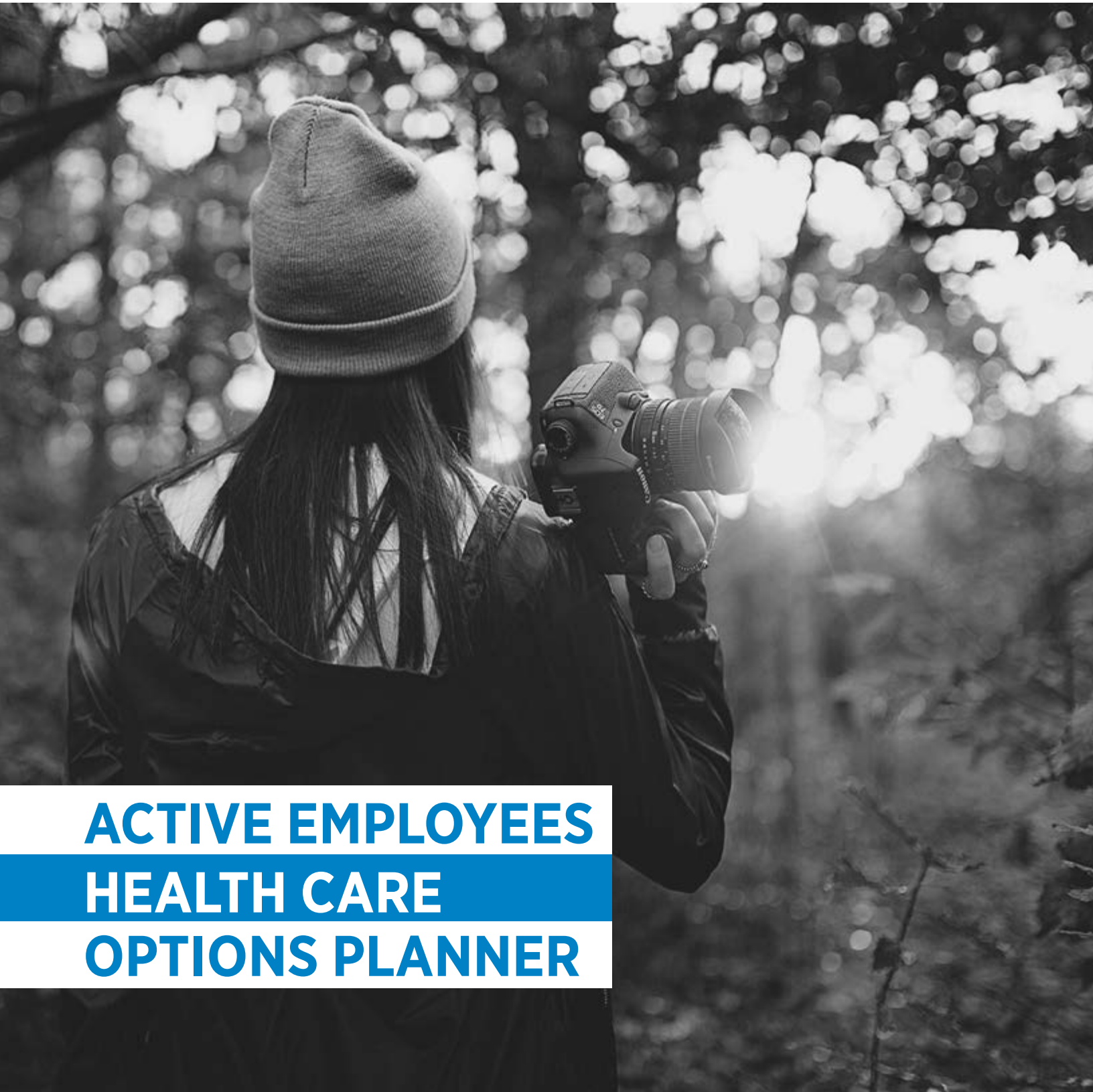
- **Reimbursement payments will be made once, after the end of the semester, via check. Checks will mailed from the Comptroller's Office to the employee's home address within 30 days after the semester ends, barring unforeseen circumstances. Direct deposit is not available.**

- **No interest will be paid on any reimbursements.**

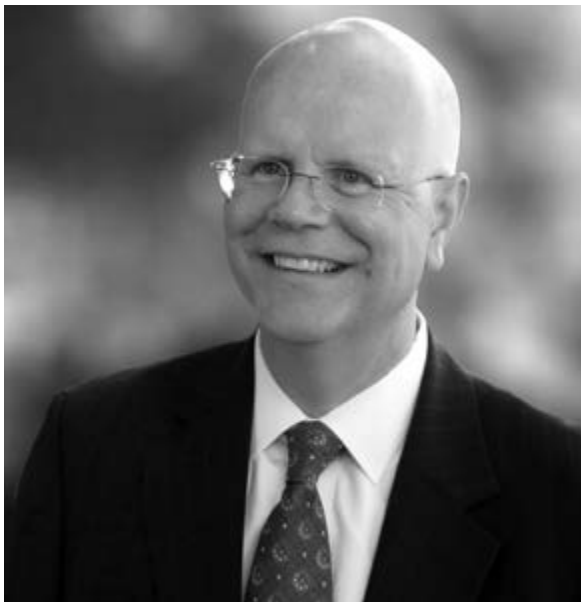
STATE OF CONNECTICUT

2016 | 2017

ACTIVE EMPLOYEES



ACTIVE EMPLOYEES HEALTH CARE OPTIONS PLANNER



A MESSAGE FROM

Kevin LEMBO

STATE COMPTROLLER

Our daily choices affect our health and what we pay out of pocket for 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 period, we encourage you to stop by one of the many fairs being held at worksites throughout the state. Members participating in the Health Enhancement Program (HEP) will have an opportunity to check their status or speak to HEP representatives – and those with a chronic condition(s) can even complete any outstanding chronic requirement(s) quickly and easily.

Whatever you decide, 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 care.

Kevin Lembo
State Comptroller

TABLE OF CONTENTS

Check Your HEP Status

The Health Enhancement Program features an easy-to-use website to keep you up to date on your requirements.

On the HEP website, you can check which HEP requirements you still have to complete, including for spouses and dependents.

What You Need to Do

Current Employees

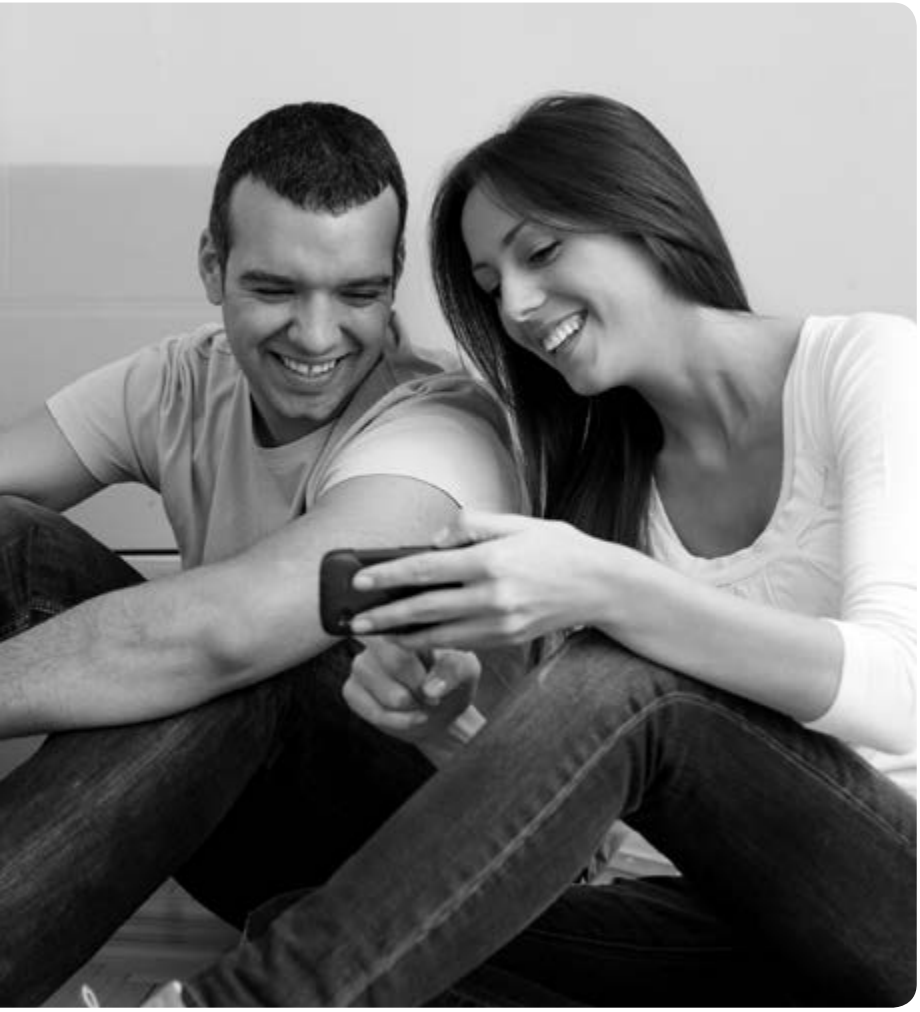
Open Enrollment Is May 9 Through June 3, 2016

Now is your opportunity to adjust 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.

For 2016 Open Enrollment information, please go to the Comptroller's website at www.osc.ct.gov or check with your agency Payroll/Human Resources office.

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

If you'd like to make a change for 2016-2017, contact your agency Payroll/Human Resources office to request an enrollment form.



New Employees

To enroll for the first time, follow these steps:

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

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

The elections you make now are effective through June 30, 2017 unless you have a qualifying status change (see page 3).

Who's Eligible

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

Eligible dependents generally include:

- Your legally married spouse or civil union partner;
- Your children up to age 26 for medical and age 19 for dental;
- Children residing with you for whom you are legal guardian (to age 18) unless proof of continued dependency is provided.

Disabled children may be covered beyond age 26 for medical or age 19 for dental, with proper documentation from the medical insurance carrier.

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

It is your responsibility to notify your agency Payroll/Human Resources office when any dependent is no longer eligible for coverage.

Refer to www.osc.ct.gov for details about dependent eligibility.

Make Sure You Cover Only Eligible Dependents

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

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

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

*** For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.**

Did you get divorced or legally separated? Once a judgement of divorce or legal separation is entered, your former spouse must be removed from the plan.

If you are covering someone who is **not** an eligible dependent, you will have to pay federal and State tax on the fair market value of benefits provided to that individual.

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

Active Employees Eligible for Medicare

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 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 plan.

Medicare Part A does not typically have a premium cost associated with enrollment. There is no harm in automatically enrolling in Medicare Part A when you or your spouse become eligible.

When you drop or otherwise lose your active employee state coverage (i.e. upon retirement), you will have a limited time to sign up for Medicare Part B with no penalty. If you are eligible for enrollment on 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 you and/or your spouse's Medicare Part B premium.

This planner provides a brief summary of covered services. See Your Benefit Resources on page 20 to receive more detailed information.

Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes for the July 1, 2016 – June 30, 2017 period unless you experience a qualifying status change. If you do have a qualifying status change, you must notify your agency Payroll/Human Resources office within 31 days of the event. The change you make must be consistent with your change in status.

Please call your agency Payroll/Human Resources office 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 your agency Payroll/Human Resources office. 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).

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[2]
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% (prior authorization may be required)		80%,[1] up to 60 inpatient days, 30 outpatient days per condition per year (prior authorization may be required)
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)
Family Planning			
Vasectomy	100% (prior authorization may be required)		80%[1] (prior authorization may be required)
Tubal Ligation	100% (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)
Hearing Aids*	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period		80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
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: $2,000 Family: $4,000		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.

* Effective 7/1/2016.

Making Your Decision

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

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

1. **What is covered** – the services and supplies that are covered benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 4.)

2. **Cost** – what you pay when you receive medical care and what is deducted from your paycheck. What you pay at the time you receive services is similar across the plans (see the chart on page 4). However, your payroll deduction varies quite a bit depending on the carrier and plan selected (see page 19).

3. **Networks** – whether your provider or hospital has contracted with the insurance carrier. (See chart below).

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 5-12).

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

Comparing Plan Features

	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 Out of Area
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 new enrollment.**

Comparing Networks

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

If you're like many people, you made a choice when you were first hired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs.

Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same health care 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. Getting your care within the network provides the highest benefit level:

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

Is a National Network Important to You?

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

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

The State of Connecticut offers affordable options with great coverage within the region and nationwide. 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.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 20).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 20).

Using Out-of-Network Providers

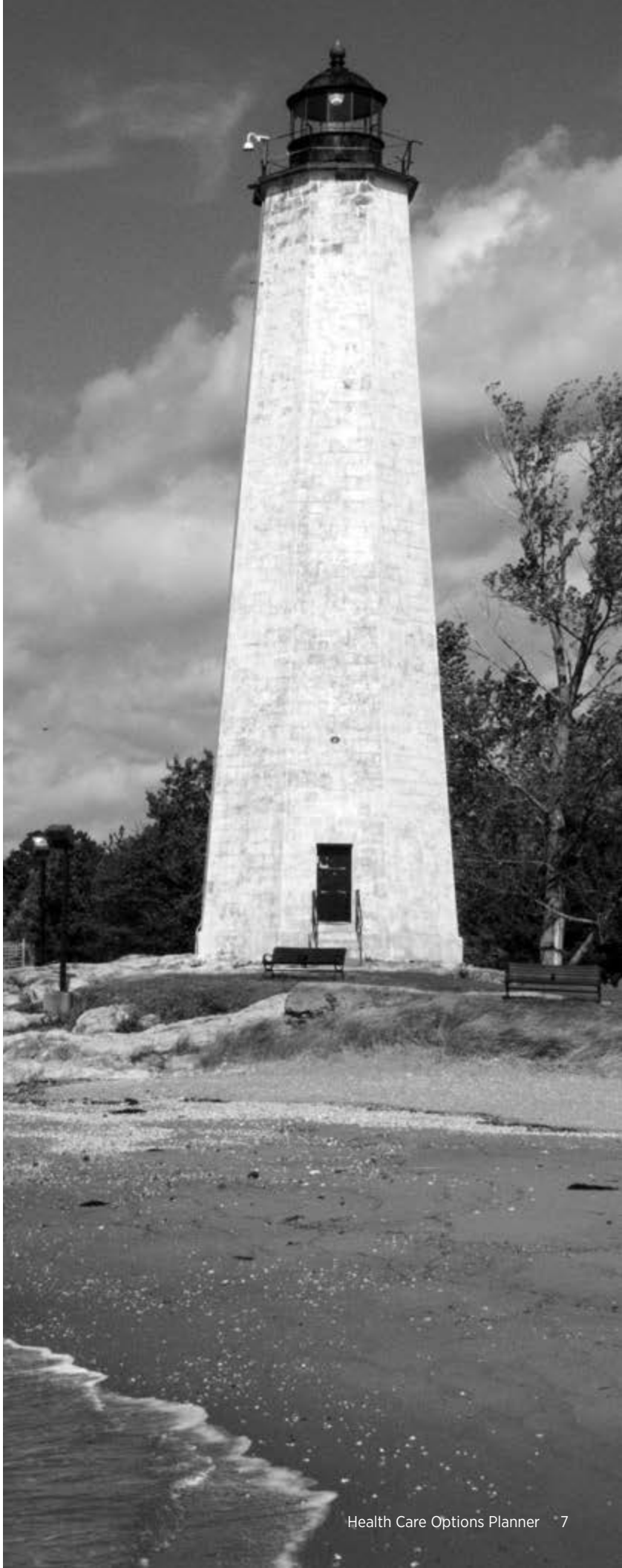
When you enroll in one of the State of Connecticut POS plans, you can choose a network or out-of-network provider each time you receive care. When you use an out-of-network provider, you'll pay more for most services. In most cases the plan pays... 80% of the allowable charge after you pay your annual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

In the POS plans there are no referral 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 4), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek 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 geographic area covered by Oxford's 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.



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.

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 below, 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.

How to Enroll in HEP

Current Employees:

For those who are not currently participating in HEP, you can enroll during open enrollment. Forms are available at your agency Payroll/Human Resources office or by visiting the Office of the State Comptroller website, www.osc.ct.gov.

Those who participated in HEP during 2015-2016 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2016-2017 and will continue to pay lower premiums for their health care coverage.

New Employees:

If you are a new employee, you must complete the HEP enrollment form upon making your benefit elections. HEP enrollment forms are available at your agency Payroll/Human Resources office or by visiting the Office of the State Comptroller website, www.osc.ct.gov. You will not have to meet the HEP requirements until the first calendar year in which you are enrolled in coverage on January 1st. If you do not wish to continue participation in HEP, you can disenroll during open enrollment.

2016 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).

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 and/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 13 for cost details).

Visit the HEP online portal at www.cthep.com to find out whether you have outstanding dental, medical or other requirements to complete by December 31, 2016. Those with chronic conditions can also complete requirements online. Care Management Solutions may also be reached by phone at (877) 687-1448.

2016 HEP Preventive Care Requirements

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 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35-39**	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT to age 75

*Dental cleanings are required for family members who are participating in one of the state dental plans
**Or as recommended by your physician

For those with a chronic condition: The household must meet all preventive and chronic requirements to be compliant.
As is currently the case under your state health plan, any medical decisions will continue to be made by you and your physician.

For More HEP Information, Visit www.cthep.com

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

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement
- 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
a ConnectiCare affiliate

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

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.

Check Your Status

You have until December 31, 2016 to complete your 2016 HEP requirements. However, right now is a great time to check your status and schedule appointments for the requirements you need to complete this year.

Good health starts with a plan

Check out our programs and services to help improve your health

Customer service: get answers and much more

The State of Connecticut Enhanced Member Service Unit can answer your questions and give you information on your benefits and our wellness programs and services.

- Call them at 1-800-922-2232.
- Visit anthem.com/statect to find information just for you.

Health and wellness programs to help you take healthy steps

Lose weight, quit smoking. Control diabetes. Get help for autism and eating disorders. We have a full range of wellness programs, online tools and resources designed to meet your needs.

24/7 NurseLine is here for you

Health problems often happen when you least expect them. Call the 24/7 NurseLine at **1-800-711-5947** to talk with a registered nurse, who can answer questions about getting care. You can talk to the nurse about your symptoms, medicines and side effects, and reliable self-care home treatments.

When you need care right away

The emergency room (ER) shouldn't be your first stop — unless it's a true emergency. Depending on the situation, there are different types of providers you can see if your doctor isn't available. This includes a walk-in doctor's office, retail health clinic and urgent care center. Call the Enhanced Member Service Unit or go to anthem.com/statect to find care near you. **Note:** Call 911 or go to the ER if you think you could put your health at serious risk by delaying care.

When you need a helping hand

We offer programs if you or a family member needs behavioral health care or substance use disorder treatment. You can reach an Anthem Behavioral Health Care Manager by calling **1-888-605-0580**. To see how to access care, visit anthem.com/statect.

Access to care — wherever you go, we've got you covered

If you travel out of Connecticut, you have access to doctors and hospitals across the country with the BlueCard® program. Call **1-800-810-BLUE (2583)** to learn more. And, with the BlueCard® Worldwide program, you have access to providers in nearly 200 countries around the world.*

Manage your benefits online — and on the go

Log on at anthem.com/statect to find a doctor, check your claims and compare costs for care near you. If you haven't registered to use the website, choose **Register Now** and follow the steps. You can also download our free mobile app by searching for "Anthem Blue Cross and Blue Shield" at the App Store® or Google PlayTM. Use the app to show your ID card, get turn-by-turn directions to a doctor or urgent care, and much more!

SpecialOffers@Anthem

Go to anthem.com/statect to find special discounts on things that encourage healthy habits. This includes weight-loss programs, gym memberships, vitamins, glasses, contact lenses and much more.

[1] Blue Cross Blue Shield Association website, Coverage Home and Away (accessed March 2016): bcbs.com/already-a-member/coverage-home-and-away.html.

Step up to better health

Comparing Plans: A Message From UnitedHealthcare

We are dedicated to helping people live healthier lives.

This is our mission and we take it seriously. By making healthier decisions, you can live a healthier life. It's that simple. Our programs and network can help you do just that.

Our Network

We have a robust local and national network. Nationally and in the tri-state area, we have a large number of doctors, health care professionals and hospitals. For years, our members have accessed 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, retirees and their families better access to care whether you are in Connecticut, traveling outside the tri-state area, or living somewhere else in the country.

Just giving you a list of doctors is not very helpful. The UnitedHealth Premium® designation program recognizes doctors who meet standards for quality and cost-efficiency. We use evidence-based medicine and national industry guidelines to evaluate quality and the cost-efficiency standards are based on local market benchmarks for the efficient use of resources in providing care. The 2016 UnitedHealth Premium program covers 27 specialty areas of medicine, including two new specialties (Ear, Nose and Throat, and Gastroenterology).

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

Administrative services provided by Oxford Health Plans. LLC. CT-15-206

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, 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 on general health information, deciding where to go for care, choosing self-care measures or guidance for difficult decisions.

Custom Website

We created this website for State of Connecticut employees and retirees to provide the tools and information to help you make informed health care decisions. Visit welcometouhc.com/stateofct to search for a doctor or hospital, or learn about the health plans we offer. You also can get Health Enhancement Program information at cthep.com, or by phone at 877-687-1448.

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.

For information on discounts and special offers, please visit welcometouhc.com/stateofct.

Frequently Asked Questions

1. Where can I get more details about what the State health insurance plan covers?

All medical plans offered by the State of Connecticut cover the same services and supplies with the same co-pays. 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 20.

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

No, as long as you work in Connecticut, you do not need to choose an Out-of-Area plan.

3. 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.

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

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

Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 20. It's likely your doctor is covered by more than one network.

5. Can I enroll later or switch plans mid-year?

The elections you make now are in effect through June 30, 2017. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 3). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

6. 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.

7. My spouse or 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 health insurance coverage as an active employee or a dependent of an active employee, you don't need to sign up for Medicare Part B while enrolled in the active state plan.

The state plan is primary as long as you're enrolled as an active employee and Medicare is secondary. This means that Medicare will only pay for services after your employee plan has made payment. It's unlikely it would be worth paying Medicare Part B premiums for secondary coverage.

Medicare Part A does not typically have a premium cost associated with enrollment. There is no harm in automatically enrolling in Medicare Part A.

When you and your spouse (if applicable) drop or otherwise lose your active employee state coverage (i.e. upon retirement), you will have a limited time to sign up for Medicare Part B with no penalty.

Your Prescription Drug Coverage at a Glance

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

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

PRESCRIPTION DRUG CO-PAYS ARE AS FOLLOWS:

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

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

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

There is $0 co-pay for medications and supplies used to treat diabetes (Type 1 and Type 2).

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

Preferred and Non-Preferred Brand-Name Drugs

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

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

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted above, 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.

Maintenance Medications

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

Mandatory 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 will be able to get your first 30-day fill of that medication at any participating pharmacy. After that your two choices are:

- Receive your medication through the Caremark mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

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

CVS Caremark Specialty Pharmacy

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

Contact Caremark

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

A CAMPAIGN TO QUIT.

KICK ASH

Find free resources to help you or your loved one to quit smoking for good.

- **The Quitline:** You can call the smoker's Quitline at 1-800-Quit-Now any time, day or night for support.
- **CVS Minute Clinics:** CVS's "Start to Stop" program offers counseling and support through their Minute Clinics. For a list of locations, visit: cvs.com/minuteclinic
- **SmokeFreeTxt:** Get encouragement, advice, and tips on how to quit smoking right to your cell phone. Sign up at: smokefree.gov/smokefreetxt
- **American Lung Association:** The American Lung Association's website offers resources and tips to help you, or someone you care about, quit smoking. Visit their website: lung.org

FOR MORE, VISIT WWW.OSC.CT.GOV/KICKASH

Your Dental Plan Choices at a Glance

Cigna is the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and Dental HMO (DHMO).
New for 2016! Implants are now covered under the DHMO.

	BASIC PLAN (any dentist)	ENHANCED PLAN (network)	DHMO® PLAN (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 100%	Covered at 100%[1]	Covered at 100%
Periodontal Maintenance[2]	Covered at 80% (if enrolled in the Health Enhancement Program, covered at 100%)	Covered at 100%[1]	Covered[3]
Periodontal Root Scaling & Planing[2]	Covered at 50%	Covered at 80%	Covered[3]
Other Periodontal Services	Covered at 50%	Covered at 80%	Covered[3]
Simple Restoration			
Fillings	Covered at 80%	Covered at 80%	Covered[3]
Oral Surgery	Covered at 67%	Covered at 80%	Covered[3]
Major Restoration			
Crowns	Covered at 67%	Covered at 67%	Covered[3]
Dentures, Fixed Bridges	Not covered[4]	Covered at 50%	Covered[3]
Implants	Not covered[4]	Covered at 50% (up to $500)	*New* Covered[3]
Orthodontia	Not covered[4]	Plan pays $1,500 per person per lifetime	Covered[3]

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

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

3 Contact CIGNA at 1-800-244-6224 for patient co-pay 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 16 for details).

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 members with qualifying medical conditions 100% reimbursement of their copay for select covered services. If you are pregnant or have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head & neck cancer radiation), you are encouraged to enroll in this program to reduce your costs. More information can be found at www.cigna.com/stateofct.

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 can get savings on most services not covered under the dental PPO plans
- You must visit network dentists to receive the Cigna dental PPO discounts (savings will not apply with non-participating dentists)
- You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment
- You are responsible for paying the negotiated fees directly to the dentist.

* *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.*

Before starting extensive dental procedures for which charges may exceed $200, your dentist may submit a pre-treatment estimate to the plan. You can also help to determine the amount you will be required to pay for a specific procedure by visiting Cigna's website at www.cigna.com.stateofct.

More details about covered services are available by contacting Cigna at 1-800-244-6224 or www.Cigna.com/stateofct.
(See Your Benefit Resources on page 20.)

Terms to Know

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

Enhanced Plan – This plan offers dental services both within and outside a 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.

If you visit a dentist who is not part of the Cigna PPO Network, he or she is considered out-of-network. The Enhanced Plan pays for covered dental services based on "MAC" or "Maximum Allowable Charge." The MAC is the amount your plan would pay had you visited an in-network dentist. When you visit an out-of-network dentist, you are responsible for any and all charges above the MAC; up to that dentist's usual charge for those services.

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.

Coverage for Fillings under the Basic and Enhanced Plan

There's not always one simple answer for treating a dental condition. You and your dentist should discuss the various options, and then you can decide on the best approach. Your costs may vary based on the treatment plan you choose.

The Basic and Enhanced Plans provide coverage for amalgam (silver) fillings. If you decide to get a composite (white) filling, you'll be responsible for paying the dentist the difference between the silver filling covered by the plan and the more expensive restoration. Both of these methods are recognized by the dental profession as acceptable treatment plans; however, the silver filling is the least costly alternative for treatment.

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

* *For your disabled child to remain an eligible dependent, they must be certified as disabled by your **medical** insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

A Message From Cigna

As a State of Connecticut employee, you and your family have the opportunity to receive quality dental care through one of the following plans:

- **Basic Plan**
- **Enhanced Plan**
- **Cigna DHMO**

Learn Before You Enroll

Employee and Retiree Website

Access your dental benefit information at: **www.cigna.com/stateofct** – the website developed by Cigna just for State of CT employees.

Cigna's Information Line

You can speak to a knowledgeable Cigna enrollment specialist 24 hours a day, 7 days a week by calling **1.800.Cigna24**. Call today to learn the following about your Cigna Dental coverage:

- Information on plan specifics
- Help finding participating dentists and specialists
- Programs and plan features available to you

Finding a Network 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**.

Once You're Enrolled:

Personalized benefit information available around the clock

Online:

Visit **www.myCigna.com**. Once registered, you can:

- Access dental plan information
- Plan your dental care with the Treatment Cost Estimator
- Check claim status and review year-to-date maximum & deductible amounts
- Verify eligibility for you and your dependents

By Phone:

Call **1.800.Cigna24**; customer service representatives are available 24/7 to answer your questions.

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.

Frequently Asked Questions

1. 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 page 15 and weigh your priorities.

2. How long can my children stay on the dental plan? Can they stay covered until their 26th birthday like with the medical plans?

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*).

** For your disabled child to remain an eligible dependent, they must be certified as disabled by your **medical** insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

3. Do any of the dental plans cover orthodontia for adults?

Yes, the Enhanced Plan and DHMO both cover orthodontia for adults up to certain limits. The Enhanced Plan pays $1,500 per person (adult or child) per lifetime. The DHMO requires a copay. The Basic Plan does not cover orthodontia for adults or children.

4. 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). And of course in the DHMO, you must use a network dentist or your exam won't be covered at all.

Your Benefit Resources

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

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 • Anthem State Preferred POS (POS)*	**www.Anthem.com/statect**	**1-800-922-2232**	
UnitedHealthcare (Oxford) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford 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)	**www.Caremark.com**	**1-800-318-2572**	
CIGNA • Basic Plan • Enhanced Plan • DHMO Plan	**www.Cigna.com/stateofct**	**1-800-244-6224**	

* **Closed to new enrollment.**