



2022/2023 Health Care Options Planner

State of Connecticut Active Employees





Natalie Braswell
State Comptroller

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Welcome!

Each year during Open Enrollment, you have the opportunity to review your current health care coverage and consider if it still meets your needs for the coming year. It's important that you take the time to consider what's happening in your life—maybe there's a child on the way, or you're preparing for a surgery. These life events could have an impact on the choices you make for coverage.

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

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

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

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2022 Open Enrollment: May 2 – May 27, 2022

Table of Contents

What's New Starting July 1, 2022	1
What You Need to Do	2
Eligibility for Coverage	3
Medical Coverage	4
Using Your Benefits.....	7
Clinical Health Programs.....	9
Prescription Drug Coverage.....	11
Dental Plan Coverage.....	12
2022/2023 Payroll Deductions.....	14
Your Benefit Resources.....	15



What's New Starting July 1, 2022

Complete Your Enrollment Online

If you want to make a change to your coverage for 2022/2023, log in to [Core-CT](#) and select [Self-Service > Benefits > Benefits Enrollment](#).

If you'd prefer, complete the Core-CT generated enrollment form from your agency benefit contact, or there is a manual change form (CO-744A) which you can find at [CareCompass.CT.gov](#). Fax, email or drop off your completed form at your agency benefits office.

| If you don't want to change your coverage, it will automatically roll over at the applicable 2022/2023 premium.

Medical Plan Name Changes

We're changing the names of some of our medical plans to better reflect the plan structure. This should help make it easier to understand the differences between the medical plans and help you choose a plan.

- **Primary Care Access**

Anthem name: State BlueCare Point of Enrollment Plus (POE-G Plus)

- **Standard Access**

Anthem name: State BlueCare Point of Enrollment (POE)

- **Expanded Access**

Anthem name: State BlueCare Point of Service (POS)

- **Quality First Select Access**— See below for more information on this new plan.

Anthem name: State BlueCare Prime Tiered POS

The name change will not affect the benefits provided under each plan.

New Medical Plan: Quality First Select Access Plan

The Quality First Select Access plan will replace the State BlueCare Prime Plus POS. If you are currently enrolled in the State BlueCare Prime Plus POS, you will automatically be enrolled in the Quality First Select Access plan starting July 1, 2022, unless you make a plan election during Open Enrollment.

The Quality First Select Access plan uses the same Prime network as the State BlueCare Prime Plus POS; however, you'll no longer need to select a PCP or get a referral to see a specialist in the State BlueCare Prime network.

Search the State BlueCare Prime network to ensure your doctors and specialists are in this plan. To save on out-of-pocket costs, use providers marked Value Tier 1—you'll pay a \$0 copay. With a Tier 2 provider, you'll pay more for care: \$50 copay for PCPs and \$100 copay for specialists. Hartford HealthCare facilities and providers are NOT in this plan's network.

Dependent Dental Coverage Extended to Age 26

Eligible dependents can now remain enrolled in State-sponsored dental coverage through the end of the year in which they turn age 26.

If you previously disenrolled a dependent from dental coverage because they reached the maximum age of 19, and they are still under the age of 26, you can re-enroll them in dental coverage that begins July 1, 2022.

To add a dependent to your dental coverage, log in to [Core-CT](#) and select [Self-Service > Benefits > Benefits Enrollment](#) or ask your agency benefits office for a Core-CT generated form. Fax, email or drop off your completed form at your agency benefits office.

What You Need to Do

Current Employees

Open Enrollment: May 2 – May 27, 2022

Open Enrollment is your opportunity to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best option for you for the coming year.

During Open Enrollment, you can:

- Change medical and/or dental plans,
- Add or drop coverage for your eligible family members, or
- Enroll if you previously waived coverage.

New for 2022! You can make a change to your coverage through eBenefits, or if you prefer, you can still complete the Core-CT generated form, which you can get from your agency benefits contact. Fax, email or drop off your completed form at your agency benefits office.

If you don't make a change, and:

- **You're currently enrolled**, your coverage will continue as is, with applicable 2022/2023 premiums.
- **You are NOT enrolled**, your coverage will continue to be waived.

New Employees

To enroll for the first time:

1. Review this Planner and choose the medical and dental options that best meet your needs.
2. Visit eBenefits to make your benefit elections. If you prefer, you can still complete the Core-CT generated form, which you can get from your agency benefits contact.
3. Complete your enrollment online, or return the completed form within 31 calendar days of the date you were hired. Paper forms should be faxed, emailed or dropped off at your agency benefits office.

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, 2023, unless you have a qualifying life event (see "Midyear Coverage Changes").

Midyear Coverage Changes

Once you make your coverage elections, you cannot make changes for the 2022/2023 plan year unless you have a qualifying life event, which includes changes in:

- Legal marital/civil union status, including marriage, civil union, divorce, death of a spouse, and legal separation
- Number of dependents, including changes through birth, death, adoption, and legal guardianship
- Employment status, including events that change your or your dependents' employment status and eligibility for coverage, such as:
 - Beginning or ending employment
 - Starting or returning from an unpaid leave of absence
 - Changing from part-time to full-time or vice versa
- Dependent status, including events that cause your dependent to become eligible or ineligible for coverage
- Residence, including moving out of the area you live in now, that makes it difficult or impossible to see network providers
- Loss of coverage, including events that cause you or your dependents to lose coverage from another source

If you have a qualifying life event, you must notify your agency benefits office within 31 days of the date of the event. The change you make must be consistent with the event that triggered the midyear coverage change opportunity. For example, if you have a child, you can add them to your current health care coverage, but you can't change the plan(s) in which you are enrolled. All coverage changes are effective the first day of the month following the date of the event.

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

Find more information about 2022 Open Enrollment at [CareCompass.CT.gov](https://www.carecompass.ct.gov) or by contacting your agency benefits office.



Eligibility for Coverage

Dependents you can cover under your plans generally include:

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

Coverage eligibility for disabled children beyond age 26 must be verified through Anthem. Contact Anthem at 800-922-2232 for details.

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

Visit [CareCompass.CT.gov](https://www.carecompass.ct.gov) for details about dependent eligibility.

Dependent Coverage

You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental. For example, you can enroll yourself and your child for medical, but only yourself for dental. To enroll an eligible family member in a plan, you must enroll as well.

Only Cover Eligible Dependents

It is your responsibility to notify your agency benefits office if individuals you cover are no longer eligible. If you are covering an ineligible dependent, you must pay federal and state taxes on the fair market value of benefits provided to that person.

Medicare Eligibility

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

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

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

Medical Coverage

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

- **Quality First Select Access (State BlueCare Prime Tiered POS):** A PCP and referrals to specialists are not required.
- **Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus]):** A PCP is required; you must have a referral to see a specialist. Out-of-network services are not covered, except in an emergency.
- **Standard Access (State BlueCare Point of Enrollment [POE]):** A PCP and referrals to specialists are not required. Out-of-network services are not covered, except in an emergency.
- **Expanded Access (State BlueCare Point of Service [POS]):** A PCP and referrals to specialists are not required.
- **State Preferred Point of Service (POS):*** A PCP and referrals to specialists are not required.
- **Out-of-Area (OOA):** Available if you or a covered dependent will be out of Connecticut for 90+ days during the year (for example, if you have a child at an out-of-state college).

Understanding the Plans

Choosing a medical plan might feel overwhelming, but it can be simple! All the medical plans cover the same medical benefits, services and supplies, just at different prices and with different networks.

Ask yourself these questions:

- Am I okay with selecting a primary care physician to coordinate my care?
- Am I okay with seeking a referral before seeing a specialist?
- Do I need out-of-network options for care?
- Would I rather pay more in bimonthly premiums or more out of pocket when I need care?
- Are my current providers in the network? If you're not sure, search for your providers using **Anthem's Find Care tool**.

Need help choosing a plan?

Visit carecompass.ct.gov/decisionguide to use our medical plan decision support tool!

Once you've answered these questions, take a look at this table—it should help you narrow down your options.*

	NEW! Quality First Select Access	Primary Care Access	Standard Access	Expanded Access
Primary Care Physician	Not Required	Required	Not Required	Not Required
PCP Referral	Not Required	Required	Not Required	Not Required
Includes In- and Out-of-Network Coverage	Yes	No	No	Yes
Provider Network Size	Limited	Broad	Broad	Broad
Premiums**	Lowest	Lower	Midrange	Highest

Allowable Charge

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

Need more help choosing a plan?

Contact a personal Health Navigator (866-611-8005) for help choosing the best medical plan for you and your enrolled family members.

* The State Preferred Point of Service plan is closed to new enrollments. The Out-of-Area plan is only available in specific situations when someone moves out of state.

** Find 2022/2023 premiums on page 14.

Quality First Select Access Plan

Here's how much you pay for covered services depending on where you choose to receive care.

Benefit Features	Quality First Select Access		
	In-Network Value Tier 1	In-Network Tier 2	Out-of-Network ¹
Office visit ²	You pay \$0	PCP: You pay \$50 Specialist: You pay \$100	You pay 20%, plus deductible
LiveHealth Online (telemedicine)	You pay \$0	N/A	N/A
Preventive care	You pay \$0	You pay \$0	You pay 20%, plus deductible
Walk-In Clinic/Urgent Care Center ³	You pay \$35	You pay \$35	You pay 20% plus deductible
Emergency care (waived if admitted)	You pay \$250	You pay \$250	You pay \$250
Diagnostic x-ray and lab (prior authorization required for diagnostic imaging)	Site of Service: You pay \$0	Non-Site of Service: You pay 20%	You pay 40%, plus deductible
Inpatient physician/hospital (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Outpatient surgical facility (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Ambulance (if emergency)	You pay \$0	You pay \$0	You pay \$0
Short-term rehabilitation and physical therapy (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Routine eye exam (one exam per year)	You pay \$0	You pay \$50 ⁴	You pay 50%, plus deductible
Audiology screening (one exam per year)	You pay \$0	You pay \$50	You pay 20%, plus deductible
Inpatient Mental Health/Substance Abuse (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Outpatient Mental Health/Substance Abuse	You pay \$0	You pay \$0	You pay 20%, plus deductible
Family planning: vasectomy or tubal ligation (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Durable medical equipment (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Skilled nursing facility (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Home health care (up to 200 visits per year; prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Annual deductible	\$0 ⁵		Individual: \$500 ⁵ Family: \$1,500 ⁵
Annual out-of-pocket maximum	Individual: \$3,000 Family: \$6,000		Individual: \$6,000 Family: \$12,000

¹ You pay coinsurance plus 100% of any amount your provider bills over the allowable charge (balance billing).

² PCP telemedicine visits are covered the same as office visits.

³ Hartford Hospital Centers are considered out-of-network.

⁴ Health Enhancement Program participants have \$50 copay waived once every two years.

⁵ Non-HEP Compliant: Additional \$350 per individual; \$1,400 maximum per family

All Other Medical Plans

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

Benefit Features	Primary Care Access Standard Access	Expanded Access State Preferred POS ¹ Out-of-Area	
	In-Network ONLY	In-Network	Out-of-Network ²
Walk-In Clinic/Urgent Care Center	You pay \$15	You pay \$15	You pay 20%, plus deductible
LiveHealth Online (telemedicine)	You pay \$5	You pay \$5	N/A
Preventive care	You pay \$0	You pay \$0	You pay 20%, plus deductible
Emergency care (waived if admitted)	You pay \$250	You pay \$250	You pay \$250
Diagnostic x-ray and lab (prior authorization required for diagnostic imaging)	Site of Service	You pay \$0	N/A
	Non-Site of Service	You pay 20%	You pay 40%, plus deductible
Inpatient physician/hospital (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Outpatient surgical facility (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Ambulance (if emergency)	You pay \$0	You pay \$0	You pay \$0
Short-term rehabilitation and physical therapy (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible; up to 60 inpatient days, 30 outpatient days per condition per year
Routine eye exam (one exam per year)	You pay \$15 ³	You pay \$15 ³	You pay 50%, plus deductible
Audiology screening (one exam per year)	You pay \$15	You pay \$15	You pay 20%, plus deductible
Inpatient Mental Health/Substance Abuse (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Outpatient Mental Health/Substance Abuse	You pay \$15	You pay \$15	You pay 20%, plus deductible
Family planning: vasectomy or tubal ligation (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Durable medical equipment (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
Skilled nursing facility (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible; up to 60 days per year
Home health care (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible; up to 200 visits per year
Annual deductible	\$0 ⁴	\$0 ⁴	Individual: \$300 ⁴ Family: \$900 ⁴
Annual out-of-pocket maximum	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000, plus deductible Family: \$4,000, plus deductible

¹ Closed to new enrollments

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

³ Health Enhancement Program participants have \$15 copay waived once every two years.

⁴ Non-HEP Compliant: Additional \$350 per individual; \$1,400 maximum per family

Using Your Benefits

Use these programs and tools to maximize your benefits and get help making important health care decisions. **It doesn't matter which medical plan you enroll in—you have access to all of these benefits regardless of your choice.**

When you need to find the best provider for your care...

Use the online **Providers of Distinction Search** to search by procedure, provider or facility, or call 866-611-8005 to speak with a personal Health Navigator.

Doctors, hospitals and provider groups that meet the highest patient care standards are designated “Providers of Distinction.” Providers of Distinction members will coordinate your care throughout your entire treatment process, from evaluation through recovery. The best providers within this program are identified as Centers of Excellence.

Earn incentives

If you select a Provider of Distinction for a qualifying procedure, you can earn a cash reward! There are over 20 qualifying procedures, including:

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

To view a full list of procedures, visit **CareCompass.CT.gov/providersofdistinction/#incentives**. **Note:** The amount of the reward varies by procedure and location.

When you need support...

You and any enrolled dependents can speak with a personal Health Navigator (866-611-8005) for help understanding your benefits, finding a doctor, and dealing with the complexities of health care. The support you'll receive will be highly coordinated with the member services teams at Anthem, Cigna, CVS Caremark and Care Management Solutions to make it easier for you to navigate your benefits and access the right care for you.

Chat with a professional Navigator 8 a.m. – 10 p.m., Monday – Friday, at 866-611-8005, or email answers@healthadvocate.com.

When you need a lab test, x-ray or imaging service...

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

When you're injured...

Your health plan has resources to help you through orthopedic injuries, from diagnosis to minor aches and pains, to surgery and recovery.

Get help diagnosing minor or lingering injuries through a virtual visit. Your provider will help create a rehab program you can do at home.

For surgical procedures, find the best providers for the care you need. Learn more at **CareCompass.CT.gov/orthopedics**.

When you need information about your benefits...

Check out **CareCompass.CT.gov**, your one-stop-shop for state benefits, including benefit charts, plan documents, carrier contact information and more.

Then, download apps from your benefit vendors:

- **Anthem:** Use the Sydney Health app (**App Store** or **Google Play**) to check your benefits, review your claims and ID cards, and get fast answers using the interactive chat feature.
- **CVS Caremark:** Use the CVS Caremark app (**App Store** or **Google Play**) to view ID cards, refill prescriptions, track your order status, view your prescription history, and find a pharmacy.
- **Cigna:** Use the myCigna app (**App Store** or **Google Play**) to check your benefits, review your claims and ID cards, search for in-network dental providers, and contact the customer service center.



When you're traveling...

Within the U.S.: You have access to doctors and hospitals across the country with the BlueCard® program. If you'll be out of state for over a month, contact a personal Health Navigator at 866-611-8005 for help switching to the Out-of-Area plan.

Internationally: You have access to providers in nearly 200 countries with the Blue Cross Blue Shield Global Core® program.

Call 800-810-2583 to learn more about both programs. If you're outside the U.S., call collect at 804-673-1177.

When you can't make it to the doctor...

LiveHealth Online

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

Get started by going to livehealthonline.com or downloading the free app (**App Store** or **Google Play**). Spanish-speaking members can use Cuidado Médico through LiveHealth Online to schedule a video visit with a Spanish-speaking doctor, 7 a.m. to 11 p.m., seven days a week. Site registration is required.

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

Sydney Health App

Download the Sydney Health app from the **App Store** or **Google Play** to connect with a doctor who can help diagnose your condition, prescribe medications, and recommend follow-up care. You'll pay nothing for a virtual (telehealth) preventive care visit with your doctor.



Clinical Health Programs

Help Managing and Preventing Diabetes

Manage your diabetes with help from the Livongo diabetes management program. Monitor your conditions through digitally connected devices, receive health nudges, and access 24/7 digital and live coaching, all from home at no cost.

This 12-month program focuses on improving lifestyle behaviors to reduce diabetes risk.

If you have prediabetes, the digital Diabetes Prevention Program can help you prevent diabetes by focusing on lifestyle changes.

To learn more about these programs, visit [CareCompass.CT.gov/diabetes](https://carecompass.ct.gov/diabetes).

Health Enhancement Program

The Health Enhancement Program (HEP) helps you and your family stay healthy while saving money on your health care costs! Participation is voluntary.

How to Enroll

- **Current employees:** Those enrolled in 2021 will automatically be re-enrolled for 2022/2023. If you are not currently participating in HEP, you can enroll during Open Enrollment. Form CO-1314 is available at your agency benefits office or by visiting [CareCompass.CT.gov/forms](https://carecompass.ct.gov/forms).
- **New employees:** If you are a new employee, you must complete the HEP enrollment form when you make your benefit elections. The HEP enrollment form (CO-1314) is available at your agency benefits office or by visiting [CareCompass.CT.gov/forms](https://carecompass.ct.gov/forms). You will not have to meet HEP requirements until the first full calendar year in which you are enrolled in coverage. If you do not wish to participate in HEP, you can disenroll during Open Enrollment.

2022 Requirements

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

Visit the [HEP online portal](#) to find out whether you have outstanding dental, medical or other requirements. HEP requirements must be completed by December 31. Those with chronic conditions can complete certain requirements online. If you have a question, contact Care Management Solutions, the administrator for HEP, at 877-687-1448.

Save Big with HEP!

When you and all your enrolled family members participate in HEP, you will pay lower monthly premiums and have no in-network deductible for the plan year. If you or an enrolled family member has a chronic condition and you complete the HEP requirements, you may receive a \$100 incentive and save money on prescription drugs.

Chronic Condition Requirements

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

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

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



2022 HEP Required Exams and Screenings

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

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

** Or as recommended by your physician

Prescription Drug Coverage

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

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

Here's what you'll pay for covered prescription drugs.

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

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

If you are enrolled in HEP (see page 9), you'll pay lower copays for medications used to treat certain chronic conditions:

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

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

Check your prescription's tier at caremark.com. Once you register, click [Look up Copay and Formulary Status](#). Type the name of the drug you want to look up, and you will see the cost and copay amounts for that drug as well as alternatives.

Brand Name Drugs

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

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

Mandatory Generics

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

90-Day Supply for Maintenance Medications

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

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

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

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

CVS Caremark Specialty Pharmacy

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

New! When you fill a prescription for a specialty drug, you will automatically be enrolled in a PrudentRx program that reduces your out of pocket cost to \$0. You can choose to opt out of this program.

To view the Specialty Drug list, go to CareCompass.CT.gov/state/pharmacy.

Contact CVS Caremark

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

Dental Plan Coverage

The State of Connecticut fully covers the cost of employee dental coverage. That means if you have Employee Only coverage, you'll pay \$0 in dental premiums! You'll pay to cover any dependents; [see page 14](#) for premiums. Cigna is the administrator for all State of Connecticut dental plans.

Need help choosing a dental plan?

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

	Cigna Dental Care DHMO Plan	Total Care DHMO Plan	Enhanced Plan	Basic Plan
Primary Care Dentist	Required	Required	Not Required	Not Required
Referred from Primary Care Dentist	Required	Required	Not Required	Not Required
In- and Out-of-Network Coverage*	No	No	Yes	Yes
What you pay when you get care	Copays	Coinsurance	Coinsurance	Coinsurance

* When you visit an out-of-network dentist, you are responsible for all charges above the maximum allowable charge—the amount the plan would have paid if you had visited an in-network dentist

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

	Cigna Dental Care DHMO Plan	Total Care DHMO Plan	Enhanced Plan	Basic Plan
Annual deductible	None	None	Individual: \$25 Family: \$75	None
Annual maximum	None	None	\$3,000 per person (excluding orthodontia)	None
Exams, cleanings and x-rays	Plan pays 100%	Plan pays 100%	Plan pays 100%, deductible does not apply ¹	Plan pays 100%
Periodontal maintenance²	Copay ³	15% coinsurance, plan pays 85%	Plan pays 100% ¹	20% (if enrolled in HEP, plan pays 100%)
Periodontal root scaling and planing²	Copay ³	15% coinsurance, plan pays 85%	20%	50%
Other periodontal services	Copay ³	15% coinsurance, plan pays 85%	20%	50%
Simple Restoration				
Fillings	Copay ³	15% coinsurance, plan pays 85%	20%	20%
Oral surgery	Copay ³	15% coinsurance, plan pays 85%	20%	33%
Major Restorations				
Crowns	Copay ³	30% coinsurance, plan pays 70%	33%	33%
Dentures, fixed bridges	Copay ³	45% coinsurance, plan pays 55%	50%	Not covered ⁴
Implants	Copay ³	45% coinsurance, plan pays 55% (one per year)	50% (plan pays benefits up to \$500)	Not covered ⁴
Orthodontia	Copay ³	45% coinsurance, plan pays 55%	50%, plan pays maximum of \$1,500 per person per lifetime ⁵	Not covered ⁴

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

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

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

⁴ While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 13 for details).

⁵ Benefits are prorated over the course of treatment.



Consider the DHMO plans

The DHMO network continues to grow! Be sure to check your provider's status at [cigna.com/stateofct](https://www.cigna.com/stateofct). Enrolling in a DHMO plan could help you save money.

What's the difference between the two DHMOs? If you're enrolled in the Cigna Dental Care DHMO Plan, you pay copays when you need care. If you're enrolled in the Total Care DHMO Plan, you pay coinsurance when you need care.

Health Enhancement Program (HEP)

If you participate in HEP (see page 9), up to two dental cleanings per year are 100% covered.

If you are in the Enhanced plan, you must use an in-network dentist to get the full coverage. If you go out of network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge).

In the DHMOs, you must use an in-network dentist, or your exam won't be covered at all.

Oral Health Integration Program

Anyone enrolled in a State of Connecticut dental plan is eligible for Cigna's Oral Health Integration Program (OHIP). OHIP provides 100% reimbursement of certain services if you are pregnant or have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation). More information can be found at stateofct.cigna.com.

Cigna's Virtual Care Program

Get care for urgent dental concerns like a toothache, chipped tooth, infection and other oral health issues when you can't get to your regular dentist. This program is available 24 hours a day, 7 days a week at stateofct.cigna.com.

Savings on Non-Covered Services

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

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

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

Pretreatment Estimates

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

myCigna Mobile App

Download the myCigna mobile app on the [App Store](https://www.apple.com/app-store) or [Google Play](https://play.google.com/store/apps/details?id=com.cigna.ct) to get access to your personal information on the go. Through the app, you can find care and costs, view claims, update your personal information and more!

New! Eligible dependents can now remain enrolled in State-sponsored dental coverage through end of the year in which they turn age 26. [See page 1](#) for more information.

2022/2023 Payroll Deductions

Biweekly Payroll Deductions

July 1, 2022 Through June 30, 2023 (26 Pay Periods)

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

Medical Plans	Employee	Employee + 1	Family	FLES**
Quality First Select Access (State BlueCare Prime Tiered [POS])	\$39.19	\$105.38	\$135.21	\$77.73
Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus])	\$49.83	\$134.44	\$170.97	\$93.48
Standard Access (State BlueCare Point of Enrollment [POE])	\$54.12	\$151.50	\$198.42	\$104.49
Expanded Access (State BlueCare Point of Service [POS])	\$64.11	\$172.39	\$204.60	\$113.48
State Preferred POS*	\$112.20	\$327.68	\$385.15	\$224.66
Out-of-Area	\$67.79	\$210.18	\$245.86	\$119.62

Dental Plans	Employee	Employee + 1	Family	FLES**
Basic	\$0.00	\$11.20	\$11.20	\$5.74
Enhanced	\$0.00	\$9.47	\$9.47	\$4.85
Cigna Dental Care DHMO	\$0.00	\$4.02	\$5.70	\$2.34
Total Care DHMO	\$0.00	\$5.01	\$7.10	\$2.93

* Closed to new enrollment

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

Your Benefit Resources

Speak with a personal Health Navigator (866-611-8005) for help understanding your benefits, finding a doctor, and dealing with the complexities of the health care. They should be your first call when you have a benefits-related question.

Phone: 866-611-8005

Website: [CareCompass.CT.gov](https://www.CareCompass.CT.gov)

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





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[CareCompass.CT.gov](https://www.CareCompass.CT.gov)

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