Special Payroll Unsubsidized

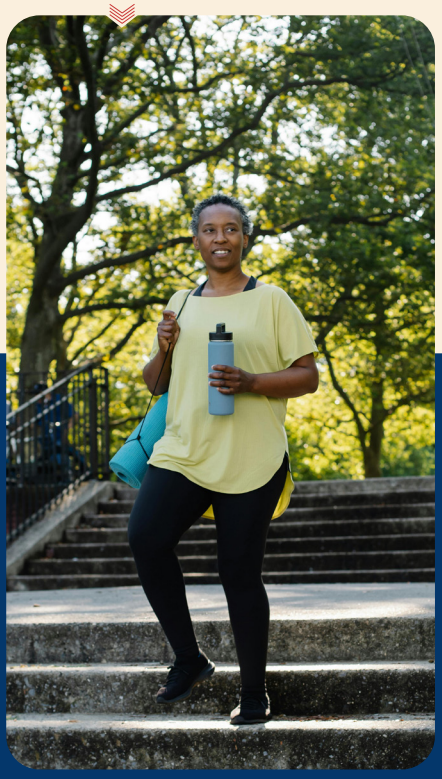
2025
2026

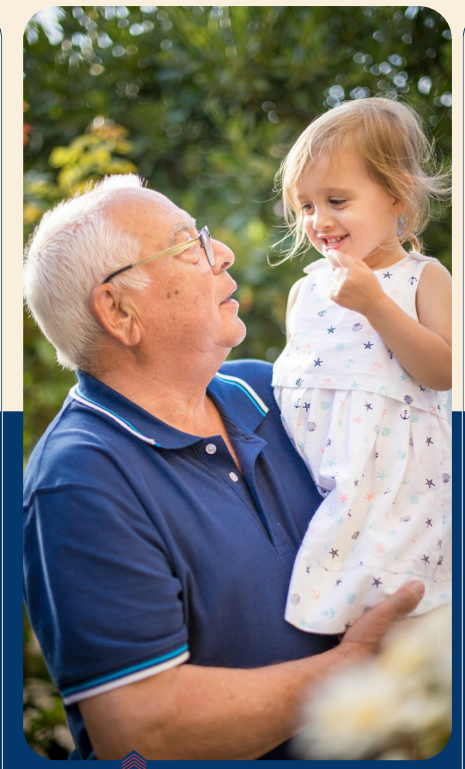
CARE COMPASS

HEALTH CARE OPTIONS PLANNER

FOR **ACTIVE** STATE OF CONNECTICUT EMPLOYEES

YOUR *health*





YOUR *family*

YOUR *benefits*

Produced by the Office of the State Comptroller,
Administrator of the State of Connecticut Health Plan.

YOUR *online benefits resource:*
carecompass.ct.gov

Sean Scanlon
State Comptroller
@CTComptroller

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.

Sean Scanlon
Connecticut State Comptroller

2025 OPEN ENROLLMENT
May 1 – May 31, 2025

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Have questions?
Contact a Care Coordinator:
Phone: 833-740-3258
CareCompass.CT.gov

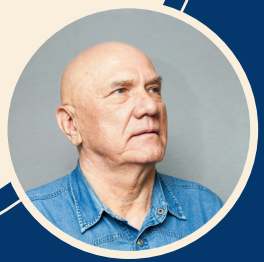
Benefits that fit YOUR life.

"My son needs braces. Which dental plan will cover more of the cost?"

Dental Plan Coverage, page 12

"How do I remove a dependent from my coverage?"

Dependent Eligibility, page 3



"I need a knee replacement. How do I find a surgeon?"

Providers of Distinction, page 7

Plan Year 2025/2026 Open Enrollment

To make changes to your coverage for 2025/2026, including selecting new medical or dental plans, log in to **Core-CT** and select **Self-Service > Benefit Details > Benefits Enrollment.**

If you'd prefer to complete a form, your agency benefit specialist can provide a Core-CT generated enrollment form.

Plan Changes

Quality First Network Expands

The Quality First Select Access medical plan now includes Hartford Healthcare doctors, providers, and facilities within the network. This plan provides great value and is only available to Connecticut residents.

View medical plan comparisons on page 4 and payroll deduction information on page 14.

Dental Plans Simplified

The Dental Care DHMO plan is closed for future enrollments. An alternative option, the Total Care DHMO plan, uses the same network but offers better benefits at lower costs. If you're currently in the Dental Care DHMO plan, you can choose to remain, or pick a different plan option.

Dental Coverage Changes, Take a Fresh Look

The Enhanced and Basic dental plans have coverage adjustments this year. Take a moment to compare plans and pick the one that meets your expected needs. You may be able to save money without changing your dental routine.

Compare dental plans on page 12.

Update your dependents

A dependent verification will begin in June 2025. **If you have ineligible dependents enrolled in your health benefits, remove them by May 31 2025** to avoid financial penalties.

Be on the lookout for information sent to your home about the verification process.

What is a "life event?"

Open Enrollment is your one chance each year to change your medical and dental coverage. Mid-year changes are only allowed if you have a qualifying "life event," like marriage, birth, or loss of other coverage.

The full list of qualifying life events is on ***page 2*** under ***Midyear Coverage Changes***.

Review Plans Before Renewing

Even if you don't change medical or dental plans, the amount of your payroll deduction might.

Take a look at the ***2025-2026 premiums*** on ***page 14***. Pick the plan that meets your health needs, and your financial needs.

What You Need to Do

Current Employees

Open Enrollment: May 1 – May 31, 2025

Open Enrollment is your chance to review your options, consider any changes in your family's needs, and choose the plans that work best for the year ahead. During this time, you can:

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

Making a change is easy! Use eBenefits to make changes to your coverage.

- Log in to Core-CT and select: **Self-Service > Benefit Details > Benefits Enrollment**.

An eBenefits guide is available on ***CareCompass.ct.gov***.

If you prefer to complete a form, your agency benefits contact can provide one. Fax, email or drop off your completed form at your agency benefits office.

If you don't make a change...

- You will automatically continue in your medical and dental plans. Your coverage will continue, with new premiums for 2025/2026 listed on ***page 14***.
- If you are not currently enrolled in any plan, your coverage will continue to be waived.

New Employees

To enroll for the first time:

1. Review this Planner or New Hire Guide 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 specialist.
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, 2026, 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 2025/2026 plan year unless you have a qualifying life event, which includes changes in:

- Legal marital/civil union status, including marriage, civil union, divorce/legal separation, death of a dependent
- Number of dependents, including changes through *birth, death, adoption, and legal guardianship
- Employment status, including events that change your 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, if you move in or out of Connecticut, making it difficult or impossible to see providers in certain plan networks
- Loss of coverage, including events that cause you or your dependents to lose coverage from another source

If you experience a qualifying life event and need to make a change, you must notify your agency benefits office ***within 31 days*** of the event. You will only be able to make changes related to the event. For example, if you have a child, you can add them to your current medical coverage, but you can't change plans until the next Open Enrollment period. All coverage changes are effective the first day of the month following the date of the event.

You have help, if you need it. 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).

You can also call a Care Coordinator at: 833-740-3258.

**Effective 7/1/2024, newborns can be enrolled in coverage up to 91 days after the date of birth. Contact your agency benefits specialists with any other questions.*

NO CHANGES? NO WORRIES.

Your current coverage will automatically continue.

View 2025/2026 premiums on page 14.

Eligibility for Coverage

Who You Can Cover

You can cover dependents under your medical and dentals plans. That generally includes:

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

You will need to provide documentation to confirm an eligible relationship when enrolling a family member. For eligibility questions, contact your agency's benefits specialist.

Dependent Coverage

You and the family members you enroll must all have the same medical and dental plans. 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.

It is your responsibility to only cover eligible dependents. This information will be subject to audit.

Medicare Eligibility & Active Employees

If you or your spouse are age 65 or older and enrolled in the active employee health plan, you ***do not*** need to enroll in Medicare Part B until you retire or leave state service.

The state plan for active employees is the primary source of your coverage. 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 active employees or their dependents.

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

When your active employee state coverage ends (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.

Guides to help you navigate changes to your coverage at retirement are available at ***carecompass.ct.gov***.

Medical Coverage

Understanding Your Plan Options

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.

Need help choosing a plan?

Easy-to-use, online decision-making tools at **carecompass.ct.gov/decisionguide**

Or call a Care Coordinator at **(833-740-3258)** for help choosing the best plans for you.

Ask yourself these questions:

- Am I okay with selecting a primary care provider (PCP) 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 payroll deductions (premiums) or more out-of-pocket when I need care?
- Are my current providers in the network? If you're not sure, use the ***Find Provider tool*** found at ***carecompass.ct.gov/benefits-enrollment***.

Once you've answered those questions, find the plan that best meets your needs using the table below.

- **Quality First Select Access (State BlueCare Prime Tiered POS):** This is the most affordable plan, with a smaller network of providers primarily in Connecticut and some nearby states. Employees and covered dependents must live in Connecticut to enroll. As of October 1, 2024, Hartford Healthcare providers and facilities are included. No referrals are needed to see specialists.
- **Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G]):** A Primary Care Provider (PCP) is required in this plan; you must have a referral to see a specialist. Out-of-network services are not covered, except in an emergency.
- **Out-of-Area (OOA):** Available if the employee moves out of Connecticut.
- **Standard Access (State BlueCare Point of Enrollment [POE]):** This plan does not require referrals for specialists, or the selection of a Primary Care Provider (PCP). Out-of-network services are not covered, except in an emergency.
- **Expanded Access (State BlueCare Point of Service [POS]):** The most expensive plan, it allows you in- and out-of-network coverage. Out-of-network services are covered at 80% of the allowable charge.
- **State Preferred Point of Service (POS):** A Primary Care Provider (PCP) and referrals to specialists are not required. *Closed to new enrollment.*

	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	Connecticut-based providers	Broad	Broad	Broad
Premiums	Lowest	Lower	Midrange	Highest

COMPARE PREMIUMS
PAGE 14

What is an "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.

Quality First Select Access Plan

Your costs in this plan vary based on where you receive care. Use the chart below to compare coverage and out-of-pocket costs. **Note: You and your covered dependents must live in Connecticut to enroll in this plan.**

Benefit Features		Quality First Select Access		
		In-Network Value Tier 1	In-Network Tier 2	Out-of-Network[1]
Office/PCP telemedicine visit		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		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 lab	Site of Service	You pay $0	You pay $0	N/A
	Non-Site of Service	You pay 20%	You pay 20%	You pay 40%, plus deductible
Diagnostic x-ray (prior authorization required for high-cost diagnostic imaging)		You pay $0	You pay $0	You pay 20%, 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	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[2]		Individual: $500[2] Family: $1,500[2]
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] *Non-HEP Compliant: Additional $350 per individual; $1,400 maximum per family*

All Other Medical Plans

What you pay for covered services depends on your plan and where you get 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]
Office/PCP telemedicine visit		$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
Walk-In Clinic/Urgent Care Center		You pay $15	You pay $15	You pay 20%, plus deductible
Emergency care (waived if admitted)		You pay $250	You pay $250	You pay $250
Diagnostic lab	Site of Service	You pay $0	You pay $0	N/A
	Non-Site of Service	You pay 20%	You pay 20%	You pay 40%, plus deductible
Diagnostic x-ray (prior authorization required for high-cost diagnostic imaging)		You pay $0	You pay $0	You pay 20%, 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	You pay $15	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 (up to 200 visits per year; prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible; up to 200 visits per year
Annual deductible		$0[3]		Individual: $300[3] Family: $900[3]
Annual out-of-pocket maximum		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] Non-HEP Compliant: Additional $350 per individual; $1,400 maximum per family

**** $0 copay for a HEP Chronic Condition visit*

Using Your Benefits

Use these programs and tools to get the most out of your benefits, find the right provider, and avoid unnecessary costs. **It doesn't matter which medical plan you enroll in, all members in every plan have access to these benefits.**

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

You can easily find the providers with the highest patient care standards when you need specific procedures or treatment for certain conditions. The ***"Providers of Distinction"*** program is simple to use and rewards you for participating!

Visit ***carecompass.ct.gov/providersofdistinction*** to search by procedure or provider, or call 833-740-3258 to speak with a personal Care Coordinator.

Earn incentives

If you select a Provider of Distinction for a qualifying procedure, you can earn an incentive! There are 300 eligible providers in Connecticut. The procedures include:

- Colonoscopy (you get $100)
- Endoscopy ($100)
- Hip Replacement ($500)
- Knee Arthroscopy ($150)
- Knee Replacement and Knee Revision ($500)
- Pregnancy and Delivery (prenatal care) ($250)
- Back and spine pain management ($100)

To learn more about the program, visit ***carecompass.ct.gov/providersofdistinction***.

FIND ALL PROVIDERS WITHIN YOUR PLAN
"Find Provider" on carecompass.ct.gov

When you need routine lab work…

Lab tests (such as blood tests) are completely free to you ($0 copay) if you use one of many preferred labs, known as *Site of Service* providers. To find a nearby participating provider, contact a Care Coordinator or *use the Find Provider* tool on ***carecompass.ct.gov***.

When moving hurts…

Get expert help with orthopedic injuries, from diagnosis of minor aches and pains, to surgery and recovery with virtual care options, in-person appointments, and a Spine Health program.

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

When you want to talk to a human…

You and any enrolled dependent can speak with a personal Care Coordinator (833-740-3258) for help understanding your benefits, finding a doctor, and dealing with the complexities of health care. ***Quantum Health*** coordinates with your medical, pharmacy, and dental member service teams, making it easier for you to get answers and guidance. Chat with a Care Coordinator: **8:30 a.m. – 10 p.m., Monday – Friday, at 833-740-3258**, or send a message through the secure portal.

When you're traveling…

In the U.S.: You can use doctors and hospitals across the country in Anthem's BlueCard® program. In an emergency, you may need to pay upfront and submit documentation to Anthem for reimbursement.

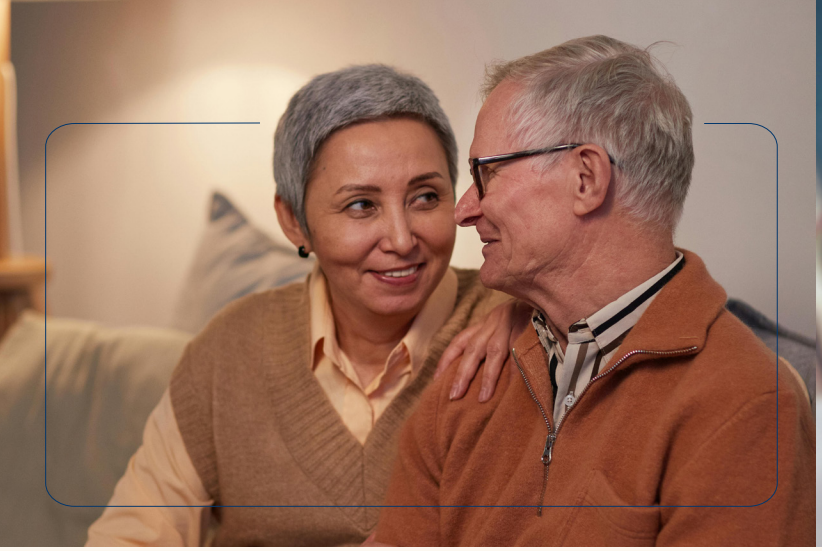
International: Access care in nearly 200 countries through Blue Cross Blue Shield Global Core®. Call a Care Coordinator to set up coverage prior to your international travel.

Call a Care Coordinator for assistance or to arrange international coverage at 833-740-3258. If you're outside the U.S., call collect at 804-673-1177.

When you need to take care of your mental health…

It's important to care for your mental and emotional health and your plan makes it easy to find providers and resources. Your benefits include coverage for behavioral health, substance use treatment, and addiction recovery.

Learn more at ***carecompass.ct.gov/mental-health***.



When you need information about your benefits...

One website: All of the information about your benefits and coverage is online at ***carecompass.ct.gov***. Select the "State Employee" option to see medical, dental, pharmacy, and supplemental benefits information for you.

Your benefits portal and app: When you log in to the benefits portal, you'll receive personalized information about your benefits. Visit ***carecompass.quantum-health.com***, or click "Log In" on the Care Compass home page.

DOWNLOAD THE MyQ APP
on Apple & Google App Store

Personal Care Coordinators: A support team is available to help you navigate the complexities of health care, including finding doctors, understanding billing, and knowing what's covered. Send a secure message in the portal, or give them a call at 833-740-3258. Hours: Monday-Friday, 8:30 a.m.-10 p.m. ET

Using eBenefits: You can make changes to coverage using the eBenefits tool on Core-CT. This feature recently received a new look. A step-by-step guide to help you use eBenefits is available by browsing ***carecompass.ct.gov/benefits-enrollment***.

When you're looking for a specialist or a doctor near you...

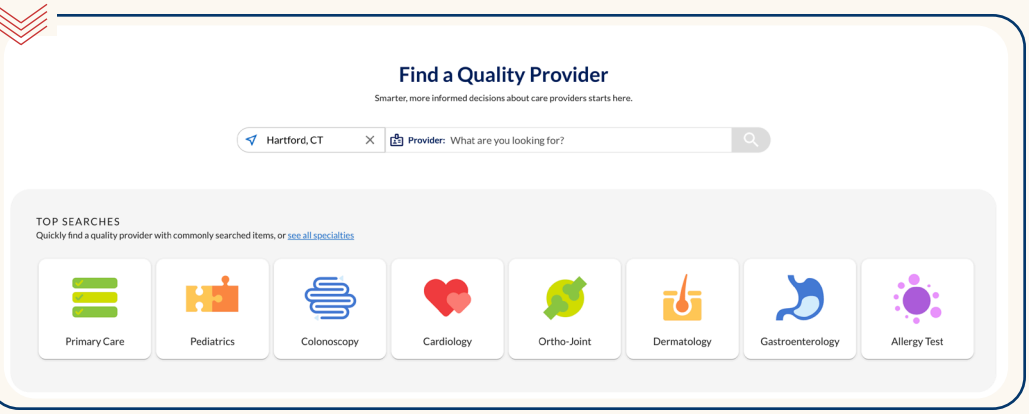
Whether you need to find a new provider or just want to check if a doctor is in your plan's network, the Find a Provider tool on ***carecompass.ct.gov*** makes it easy.

You can search by provider name, medical group, facility, location, or specialty.

The tool has been upgraded to offer smarter results—it can suggest providers based on your needs, explain why they're a match, and even help you out if you're not sure how to spell a doctor's name.

It's a helpful first stop when you're planning your care.

FIND A PROVIDER TOOL



Submitting an out-of-network claim

Each medical plan has unique rules for out-of-network claims, but it is important that you submit documentation for maximum reimbursements.

To do so, log into your personal benefits portal. Select **My Plan > Claims** and follow the instructions. If you need assistance, contact a Care Coordinator.

Healthy Living Programs

Manage, or Reverse Diabetes

Get support managing Type 1 or Type 2 diabetes with Virta Health. You'll get a personal health coach, free testing supplies, and tips to manage your A1c. If you have Type 2 diabetes, you may qualify for Virta's reversal program, which offers personalized nutrition plans, support from medical providers and coaches, and digital tools to help you improve your health through lifestyle changes.

Prevent Diabetes

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

Learn more: carecompass.ct.gov/diabetes

Well-being Seminars

Join 30-minute health seminars led by Wellspark professionals on topics like stress management, quitting smoking, boosting immunity, healthy eating, meditation, chair exercises, and more. Attending a "Basics" seminar can also satisfy your HEP Chronic Condition education requirement (if applicable).

See the upcoming schedule of wellbeing seminars at carecompass.ct.gov/wellbeing-seminars

Mental Health Resources

Find mental and emotional health providers, or search by the type of support you need.

Find providers, programs and resources at carecompass.ct.gov/mental-health

Orthopedics

Get treatment or diagnosis of orthopedic injuries, at any stage of the process. You have access to orthopedic coaches, virtual physical therapy, and in-person care.

Learn more: carecompass.ct.gov/orthopedics

Note: The Health Enhancement Program is not available to Special Payroll employees who do not qualify for a State subsidy.

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 in HEP

Current employees: Your current HEP election will stay the same for the new plan year unless you make a change during Open Enrollment. If you are HEP Non-Compliant, you cannot change your election. If you are enrolling in benefits for the first time, you will automatically be enrolled in HEP.

New employees: If you're enrolling in benefits, you will be automatically enrolled in HEP unless you opt out during Open Enrollment or when making your benefit elections. You will not need to meet HEP requirements until the first full calendar year in which you are enrolled in coverage.

To opt out: If you do not enroll in HEP, you'll pay an additional $46.15 per paycheck for the cost of coverage. Form CO-1316 is available at your agency benefits office or by visiting carecompass.ct.gov/forms.

HEP Age-Based Requirements

HEP enrollees and their spouses must get age-appropriate wellness exams and early diagnosis screenings, such as colorectal cancer screenings, Pap tests and mammograms. Dependent children age 6-26 must complete at least one dental exam each year.

Visit the HEP online portal at **carecompass.quantum-health.com** to find out whether you have outstanding dental, medical or other requirements. HEP requirements must be completed by December 31. Those with chronic conditions can complete education requirements online. If you have a question, contact Quantum Health, the administrator for HEP, at 833-740-3258.

HEP Chronic Condition Requirements

You and/or your spouse 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.

2025 HEP Required Exams and Screenings

PREVENTIVE SCREENINGS	Dependent Requirements	Employee and Spouse Requirements				
	6-25 years	18-29 years	30-39 years	40-49 years	50-64 years	65+ years
Preventive Visit		Every 2 years				
Dental Cleaning	At least 1 per year	At least 1 per year				
Cholesterol Screening		Every 5 years (age 20+)				
Breast Cancer Screening (for women)		N/A		Mammogram every 2 years to age 75		
Cervical Cancer Screening (for women)		Pap every 3 years (age 21+)	Pap only every 3 years or Pap/HPV combo every 5 years			N/A
Colorectal Cancer Screening		N/A		Colonoscopy every 10 years (45+), Cologuard screening every 3 years, or Annual FIT/FOBT to age 75		

Save big with HEP

When you and your enrolled family members participate in HEP, you'll pay lower monthly premiums and no in-network deductible. If you or your spouse has a chronic condition and complete your HEP requirements, you may earn a $100 incentive and save on prescriptions.

The Health Enhancement Program has saved the lives of state employees and their family members through early detection.

Prescription Drug Coverage

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

What you pay depends on whether your prescription is a generic, a preferred brand-name (on the CVS Caremark 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 (**pages 9 and 10**), 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 in your benefits portal by clicking **My Plan > Pharmacy**. Select *Look Up Copay and Formulary Status*, enter the drug name, and view its cost, copay, and alternatives.

Brand Name Drugs

CVS Caremark's Pharmacy and Therapeutics Committee assigns drug tiers and may update them based on new clinical studies, or newly available generic or brand-name drugs. If your doctor determines a non-preferred brand is medically necessary, they must submit a Coverage Exception Request form (***carecompass.ct.gov/forms***) to CVS Caremark. If approved, you'll pay the copay amount for preferred brand drugs.

Mandatory Generics

If a generic version of a prescribed drug is available, it will be dispensed automatically. A note from your doctor saying "dispense as written" is not sufficient. Without an approved exception, choosing a brand-name drug means you'll pay the generic copay plus the cost difference between the brand and generic. Coverage Exception Request forms (***carecompass.ct.gov/forms***) must be submitted to, and approved by, CVS Caremark.

90-Day Supply for Maintenance Medications

If you or your family member takes a maintenance medication for chronic or long-term care, you are required to get your maintenance prescriptions in 90-day quantities. 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.

A list of maintenance medications and participating pharmacies is at ***carecompass.ct.gov/state/pharmacy***

Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused).

Pharmacies include Hartford Healthcare, University of Connecticut Health Center, Yale New Haven Health, and CVS Specialty Drug Pharmacy, offering expert support and resources to meet your unique medication needs. To learn more or explore these options, call (800) 237-2767.

Your out-of-pocket costs for specialty drugs will be reduced at $0 with automatic enrollment in the PrudentRx program. You can choose to opt out of this program by going to ***carecompass.ct.gov/forms***.

Go to ***carecompass.ct.gov/state/pharmacy*** to view the Specialty Drug list, or for more information.

Pharmacy Questions

If you have questions about your prescription drug benefits, visit ***CareCompass.CT.gov/state/pharmacy*** or contact a Care Coordinator at 833-740-3258.

Dental Plan Coverage

The State of Connecticut covers the full cost of Employee Only dental coverage—$0 in premiums for you! You'll only pay to cover dependents (see **page 14** for rates). All dental plans are administered by Cigna.

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

** **Out-of-network coverage for the Basic and Enhanced plans has decreased for many dental procedures. 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.**

***Closed to new enrollments; the Total Care DHMO Plan offers better coverage and lower costs**

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

	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan*
Annual deductible	None	$0 in-network, $25 & $75 out-of-network	None	None
Annual maximum	None	$5,000; $2,500 out-of-network (excluding orthodontia)	None	None
Exams, cleanings and x-rays	You pay $0	You pay $0, deductible does not apply[1]	You pay $0	You pay $0
Periodontal maintenance[2]	You pay 15%	You pay $0 in-network and out-of-network[1]	You pay 20% in-network and out-of-network, $0 for HEP enrollees	Copay[3]
Periodontal root scaling and planing[2]	You pay 15%	You pay $0 in-network, 50% out-of-network	You pay 40% in-network, 50% out-of-network	Copay[3]
Other periodontal services	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 50% in-network and out-of-network	Copay[3]
Simple Restoration				
Fillings	You pay 15%	You pay 20% in-network, 30% out-of-network	You pay 20% in-network, 30% out-of-network	Copay[3]
Oral surgery	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 30% in-network, 50% out-of-network	Copay[3]
Major Restorations				
Crowns	You pay 30%	You pay 33% in-network, 50% out-of-network	You pay 33% in-network, 50% out-of-network	Copay[3]
Dentures, fixed bridges	You pay 45%	You pay 50% in-network and out-of-network	Not covered[4]	Copay[3]
Implants	You pay 45% (one per year)	You pay 50% in-network and out-of-network (up to $500)	Not covered[4]	Copay[3]
Orthodontia	45% (24 month course of treatment — lifetime maximum)	You pay 50% (plan pays maximum of $2,000, $1,000 out-of-network, per person per lifetime)[5]	Not covered[4]	Copay[3]

[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.*

Two Free Cleanings for Each Member

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

To get full coverage, stay in-network. With the Enhanced plan, you'll get full coverage only with in-network dentists—out-of-network care may lead to balance billing. With the DHMO plans, out-of-network visits aren't covered at all

Oral Health Integration Program

If you are pregnant or have a qualifying medical condition (heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation) you can receive up to 100% cost reimbursement Cigna's Oral Health Integration Program (OHIP) is available in all dental plan options. Learn how it works and how it can help at ***stateofct.cigna.com***.

Virtual Dental Options

Need urgent dental help or nervous about the dentist? Get 24/7 care for toothaches, infections, chipped teeth and more at ***stateofct.cigna.com*** with no office visit needed.

Using the new SmartScan feature, you can even upload photos of your teeth from your smartphone to be evaluated for cavities and gum disease, a great option for people anxious about visiting the dentist

Savings on Non-Covered Services

Many dentists in the Basic and Enhanced plan networks provide lower fees for non-covered services. These savings may apply even if you've hit your annual maximum or if services are limited by age, frequency, or other plan rules. To get the discount, visit an in-network dentist and confirm the procedure is on their fee schedule before treatment. You'll pay 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 any dental procedure that may cost more than $200, your dentist can submit a pretreatment estimate to the plan. You can also check your expected out-of-pocket costs for specific procedures by contacting Cigna at 800-244-6224.

Consider the Total Care DMHO Plan

For many members, the Total Care DMHO Plan offers the lowest cost for the dental services you'll need this year. The DMHO network continues to expand and may already include your dentist. Enhancements to the Total Care DMHO plan have eliminated the need for the previous Dental Care DMHO Plan, which is now closed to future enrollments.

In your benefits portal, go to My Plan then select Dental to find providers and view dental claims.

Need help picking a plan?

Visit ***carecompass.ct.gov/benefits-enrollment*** to take the Dental Plan Quiz. After answering some simple questions, get recommendations for the plan that best fits your needs and budget.

2025/2026 Payroll Deductions

Biweekly Payroll Deductions

July 1, 2025 Through June 30, 2026

Special Payroll Employees Who Do Not Qualify for a State Subsidy

Medical Plans	Employee	Employee + 1	Family
Quality First Select Access (State BlueCare Prime Tiered [POS])	$542.53	$1,193.55	$1,464.82
Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus])	$560.96	$1,234.10	$1,514.59
Standard Access (State BlueCare Point of Enrollment [POE])	$570.42	$1,254.92	$1,540.14
Expanded Access (State BlueCare Point of Service [POS])	$570.76	$1,255.66	$1,541.05
Out-of-Area	$770.46	$1,695.01	$2,080.24

Dental Plans	Employee	Employee + 1	Family
Basic	$18.58	$56.67	$56.67
Enhanced	$18.20	$55.50	$55.50
Cigna Dental Care DHMO*	$10.91	$24.01	$29.46
Total Care DHMO	$13.61	$29.94	$36.75

** Closed to new enrollment*

Your Benefit Resources

A personal **Care Coordinator** should be your first call when you have a benefits-related question. They are trained to help you understand all of your benefits and to coordinate between all programs and partners. Your benefit needs are personal, the support you and your family get should be personal too.

Phone: 833-740-3258 **Website: carecompass.ct.gov** (secure messaging once logged-in)

Personal Benefits Portal

For a completely personalized benefits experience, use the benefits portal (from Quantum Health) accessible from ***carecompass.ct.gov*** or the ***MyQHealth*** app:

- **An advanced, custom-built provider search tool** helps you locate in-network providers for medical, pharmacy, and dental.
- **One-click access** from the benefit portal to personalized pharmacy, medical and dental websites.
- **A one-stop shop** for all of your benefit needs, like digital ID cards and claims information.
- **Personalized assistance** from Care Coordinators. They're standing by to help with your health care needs, including questions about condition management, HEP, claims, providers and coverage.

You must be enrolled in a State of Connecticut medical plan, or be an adult dependent of an enrolled member, in order to register for your personal benefit portal.

To access and register for your benefits portal:

- Go to ***carecompass.ct.gov*** and select **Benefits Login.** Then, register using the last four digits of your Medical ID (found on your Anthem card).
- You may also download the free mobile app by searching for "**MyQHealth**" at the App Store or on Google Play. If you haven't registered on the site, click **Register** and follow the steps.
- Adult dependents (age 18 and over) can register for a personal benefit account. You can share your HEP status with a family member by creating your own account, clicking Profile Settings, and selecting the Wellness/Prevention box.

Direct Contacts

Coverage	Provider	Phone	Website
General benefit questions, Medical, and Health Enhancement Program (HEP)	Quantum Health	833-740-3258	carecompass.quantum-health.com
Prescription drugs	CVS Caremark	800-318-2572	CareCompass.CT.gov/state/pharmacy Or connect to your CVS pharmacy account from your benefits portal: Login, then select, "My Plan", then "Pharmacy".
Dental	Cigna	800-244-6224	CareCompass.CT.gov/state/dental Or connect to your Cigna dental account from your benefits portal: Login, then select, "My Plan", then "Dental".

Healthcare Policy & Benefit Services Division
Office of the State Comptroller
165 Capitol Avenue
Hartford, CT 06106

CARE COMPASS

CareCompass.CT.gov

April 2025