

A Great Opportunity for Very Valuable Healthcare Coverage

Welcome to the Connecticut (CT) Partnership Plan—a low-/no-deductible Point of Service (POS) plan now available to you (and your eligible dependents up to age 26) and other non-state public employees who work for municipalities, boards of education, quasi-public agencies, and public libraries.

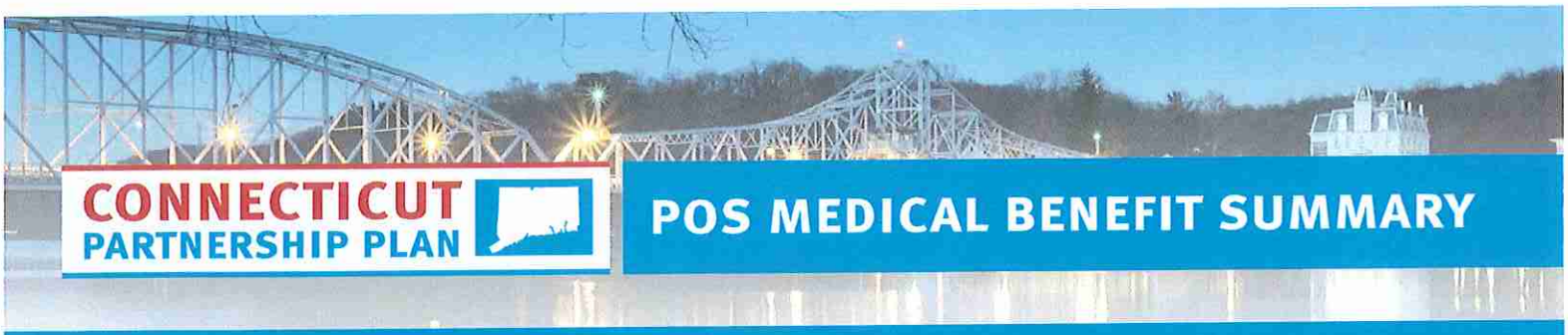
The CT Partnership Plan is the same POS plan currently offered to State of Connecticut employees. You get the same great healthcare benefits that state employees get, including $15 in-network office visits (average actual cost in CT: $150*), free preventive care, and $5 or $10 generic drug copays for your maintenance drugs. You can see any provider (e.g., doctors, hospitals, other medical facilities) you want—in- or out-of network. But, when you see in-network providers, you pay less. That's because they contract with Anthem Blue Cross and Blue Shield (Anthem)—the plan's administrator—to charge lower rates for their services. You have access to Anthem's State Bluecare POS network in Connecticut, and access to doctors and hospitals across the country through the BlueCard® program.

When you join the CT Partnership Plan, the state's Health Enhancement Program (HEP) is included. HEP encourages you to get preventive care screenings, routine wellness visits, and chronic disease education and counseling. When you remain compliant with the specific HEP requirements on page 5, you get to keep the financial incentives of the HEP program!

Look inside for a summary of medical benefits, and visit www.anthem.com/statect to find out if your doctor, hospital or other medical provider is in Anthem's network. Information about the dental plan offered where you work, and the amount you'll pay for healthcare and dental coverage, will be provided by your employer.

*Source: Healthcare Bluebook: healthcarebluebook.com

www.osc.ct.gov/ctpartner



CONNECTICUT PARTNERSHIP PLAN

POS MEDICAL BENEFIT SUMMARY

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
Preventive Care (including adult and well-child exams and immunizations, routine gynecologist visits, mammograms, colonoscopy)	$0	20% of allowable UCR* charges
Annual Deductible (amount you pay before the Plan starts paying benefits)	Individual: $350 Family: $350 per member ($1,400 maximum) ***Waived for HEP-compliant members***	Individual: $300 Family: $900
Coinsurance (the percentage of a covered expense you pay ***after*** you meet the Plan's annual deductible)	Not applicable	20% of allowable UCR* charges
Annual Out-of-Pocket Maximum (amount you pay before the Plan pays 100% of allowable/UCR* charges)	Individual: $2,000 Family: 4,000	Individual: $2,300 (includes deductible) Family: $4,900 (includes deductible)
Primary Care Office Visits	$15 copay ($0 copay for Preferred Providers)	20% of allowable UCR* charges
Specialist Office Visits	$15 copay ($0 copay for Preferred Providers)	20% of allowable UCR* charges
Urgent Care & Walk-In Center Visits	$15 copay	20% of allowable UCR* charges
Acupuncture (20 visits per year)	$15 copay	20% of allowable UCR* charges
Chiropractic Care	$0 copay	20% of allowable UCR* charges
Diagnostic Labs and X-Rays[1] ** High Cost Testing (MRI, CAT, etc.)	$0 copay (your doctor will need to get prior authorization for high-cost testing)	20% of allowable UCR* charges (you will need to get prior authorization for high-cost testing)
Durable Medical Equipment	$0 (your doctor may need to get prior authorization)	20% of allowable UCR* charges (you may need to get prior authorization)

1 IN NETWORK: Within your carrier's immediate service area, no co-pay for preferred facility. 20% cost share at non-preferred facility. Outside your carrier's immediate service area: no co-pay.

1 OUT OF NETWORK: Within your carrier's immediate service area, deductible plus 40% coinsurance. Outside of carrier's immediate service area: deductible plus 20% coinsurance.

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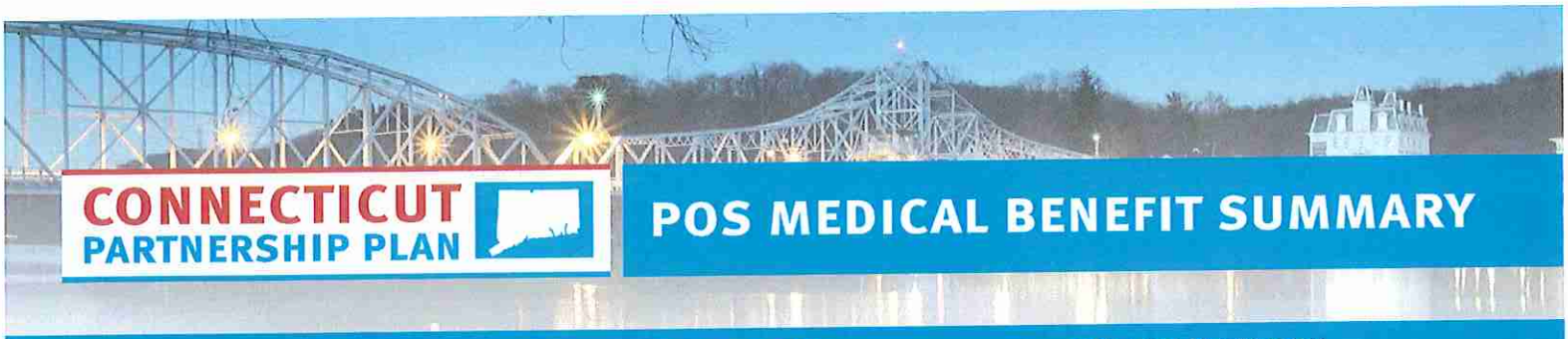

CONNECTICUT PARTNERSHIP PLAN

POS MEDICAL BENEFIT SUMMARY

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Care	$250 copay (waived if admitted)	$250 copay (waived if admitted)
Eye Exam (one per year)	$15 copay	50% of allowable UCR* charges
**Infertility (based on medical necessity)		
Office Visit	$15 copay	20% of allowable UCR* charges
Outpatient or Inpatient Hospital Care	$0	20% of allowable UCR* charges
**Inpatient Hospital Stay	$0	20% of allowable UCR* charges
Mental Healthcare/Substance Abuse Treatment		
**Inpatient	$0	20% of allowable UCR* charges (you may need to get prior authorization)
Outpatient	$15 copay	20% of allowable UCR* charges
Nutritional Counseling (Maximum of 3 visits per Covered Person per Calendar Year)	$0	20% of allowable UCR* charges
**Outpatient Surgery	$0	20% of allowable UCR* charges
**Physical/Occupational Therapy	$0	20% of allowable UCR* charges, up to 60 inpatient days and 30 outpatient days per condition per year
Foot Orthotics	$0 (your doctor may need to get prior authorization)	20% of allowable UCR* charges (you may need to get prior authorization)
Speech therapy: Covered for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	$0	Deductible plus Coinsurance (30 visits per Calendar Year)
Medically necessary treatment resulting from other causes is subject to Prior Authorization	$0 (30 visits per Covered Person per Calendar Year)	Deductible plus Coinsurance (30 visits per Calendar Year)

*Usual, Customary and Reasonable. You pay 20% coinsurance based on UCR, plus you pay 100% of amount provider bills you over UCR.

** Prior authorization required: If you use in-network providers, your provider is responsible for obtaining prior authorization from Anthem. If you use out-of-network providers, you are responsible for obtaining prior authorization from Anthem.

Be the picture of health

Check out these programs and services to be your healthy best

Need a doctor? Choose a State of Connecticut preferred doctor and save

When you see a Primary Care Physician (PCP) or specialist in your State of Connecticut preferred network (also referred to as Tier 1 in your health plan), there's no office visit copay. These doctors cost less than doctors outside of your plan.

- Visit **anthem.com/statect** and choose **Find a Doctor.**
- Call the Enhanced Member Service Unit at 1-800-922-2232, for more information or to find out if your doctor is in Tier 1.

Use Site-of-Service providers to get 100% coverage for lab tests, X-rays, and high-cost imaging

Site-of-Service (SOS) providers give you 100% coverage with a $0 copay. Your plan will cover only 80% of the cost when you get these services from other providers.

- Call the Enhanced Member Service Unit at 1-800-922-2232 to learn more.

Find support for mental health issues

If you or a family member needs mental health or substance use care or treatment, we have specialists and designated programs that can help and/or direct you to the type of care that you need.

- Call an Anthem Behavioral Health Care Manager at 1-888-605-0580.
- Visit **anthem.com/statect**.

See a doctor, psychologist or therapist from home or work with LiveHealth Online

With LiveHealth Online you can see a board-certified doctor on your smartphone, tablet or computer with a webcam. Doctors can assess your health, provide treatment options and send a prescription to the pharmacy of your choice, if needed.[2] If you're feeling stressed, worried or having a tough time, you can see a licensed psychologist or therapist through LiveHealth Online Psychology. It's private and in most cases you can see a therapist within 4 days or less.[3]

- Learn more and enroll at **livehealthonline.com** or use the free mobile app.

How to find care right away when it's not an emergency

The emergency room shouldn't be your first stop — unless it's a true emergency (then, call 911 or go to the ER). Depending on the situation, there are different types of providers you can see if your doctor isn't available.

- Visit a walk-in doctor's office, retail health clinic or urgent care center.
- Have a video visit with a doctor through LiveHealth Online.
- Call 24/7 NurseLine at 1-800-711-5947 to speak with a nurse about symptoms or get help finding the right care.

Get access to care wherever you go

If you travel out of Connecticut, but are in the U.S., you have access to doctors and hospitals across the country with the BlueCard® program. If you travel out of the U.S., you have access to providers in nearly 200 countries with the Blue Cross and Blue Shield Global Core® program.

- Call 1-800-810-BLUE (2583) to learn more about both programs. If you're outside the U.S., call collect at 1-804-673-1177.[3]

It's easy to manage your benefits online and on the go

- Find a doctor, check your claims and compare costs for care near you at anthem.com/statect.
- Use our free mobile app (search "Anthem Blue Cross and Blue Shield" at the App Store® or Google PlayTM) for benefit information and to show your ID card, get directions to a doctor or urgent care center and much more

Customer service helps you get answers and much more

The State of Connecticut Enhanced Member Service Unit can give you information on benefits, wellness programs and services and everything mentioned in this flier.

- Call them at 1-800-922-2232.
- Visit **anthem.com/statect**.

1 Designated as Tier 1 in our Find a Doctor tool. Eligible specialties include allergy and immunology, cardiology, endocrinology, ear nose and throat (ENT), gastroenterology, OB/GYN, ophthalmology, orthopedic surgery, rheumatology and urology.
2 Prescription availability is defined by physician judgment and state regulations.
3 Appointments subject to availability of therapist.
4 Blue Cross Blue Shield Association website: Coverage Home and Away (accessed March 2019): bcbs.com/already-a-member/coverage-home-and-away.html.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
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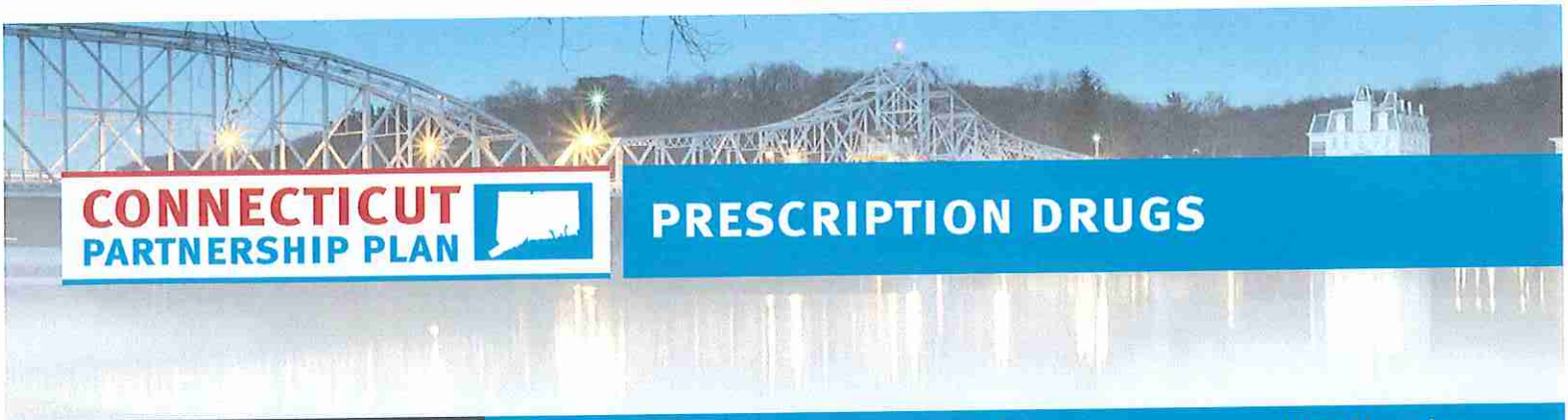

CONNECTICUT PARTNERSHIP PLAN

PRESCRIPTION DRUGS

PRESCRIPTION DRUGS	Maintenance+ (31-to-90-day supply)	Non-Maintenance (up to 30-day supply)	HEP Chronic Conditions
Generic (preferred/non-preferred)++	$5/$10	$5/$10	$0
Preferred/Listed Brand Name Drugs	$25	$25	$5
Non-Preferred/Non-Listed Brand Name Drugs	$40	$40	$12.50
Annual Out-of-Pocket Maximum	$4,600 Individual/$9,200 Family		

+ Initial 30-day supply at retail pharmacy is permitted. Thereafter, 90-day supply is required—through mail-order or at a retail pharmacy participating in the State of Connecticut Maintenance Drug Network.

++ Prescriptions are filled automatically with a generic drug if one is available, unless the prescribing physician submits a Coverage Exception Request attesting that the brand name drug is medically necessary.

Preferred and Non-Preferred Brand-Name Drugs

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

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov/ctpartner) 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.) 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.

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).

Your Personal Prescription Benefit Program

CT Partnership Plan

Your prescription benefit plan, administered by CVS Caremark, is designed to bring you quality pharmacy care that will help you save money.

Following is a brief summary of your prescription benefits. On the reverse side, you will find details about the State of Connecticut Maintenance Drug Network, which offers two ways for you to save on your long-term medications.

	Acute Medications For short-term medications (Up to a 30-day supply)	**Maintenance Medications** For long-term medications (Up to a 90-day supply) (Mandatory Mail or State of CT Maintenance Drug Network* after 1st 30-day fill at retail)	**Diabetes Maintenance Medications** For long-term medications (Up to a 90-day supply) (already in place)	**Health Enhancement Program Only** Enrolled participants with Asthma/ COPD, Heart Failure/Heart disease, Hyperlipidemia, or Hypertension qualify for reduced copays on condition-related maintenance medications (Up to a 90-day supply)
Where	The CVS Caremark Retail Network includes more than 67,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and CVS /pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-800-318-2572.	You have the convenience of getting your long-term medications through CVS Caremark Mail Service Pharmacy or dispensed at one of our 7,300 CVS/pharmacy locations as well as a retail pharmacy that participates in the State of Connecticut Maintenance Drug Network. When you use CVS Caremark Mail Service Pharmacy, your medications can be sent directly to your home or office.		
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**$5** for a generic prescription	**$5** for a generic prescription	**$0** for a generic prescription	**$0** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**$20** for a preferred brand-name prescription	**$10** for a preferred brand-name prescription	**$0** for a preferred brand-name prescription	**$5** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**$35** for a non-preferred brand-name prescription	**$25** for a non-preferred brand-name prescription	**$0** for a non-preferred brand-name prescription	**$12.50** for a non-preferred brand-name prescription
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready.			
Customer Care	Visit www.caremark.com or call toll-free at 1-800-318-2572.			
All plans are mandatory generic. If the use of the brand is medically necessary, doctors can obtain the Coverage Exception Form from Customer Care or the CT Partnership website at http://www.Caremark.com/CTPartnership.				

* State of Connecticut Maintenance Drug Network- All CVS/pharmacies are included in the State of Connecticut Maintenance Drug Network. Other retail pharmacies interested in joining can log on to www.caremark.com and click on "For Pharmacists and Medical Professionals" for more information.

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS CAREMARK

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Use Maintenance Choice to Fill Your Long-Term Medications

ABOUT THE CVS CAREMARK RETAIL NETWORK

Will I receive a new ID card when I enroll in the Health Enhancement Program?

Yes. You will receive two prescription drug cards per family. Please show this new card to your pharmacist to ensure the pharmacy has updated information.

Do I only have to use a CVS/pharmacy?

CVS Caremark pharmacy network contains more than 67,000 participating retail pharmacy chains and independent pharmacies. You can use any participating pharmacy to fill your acute (short-term) medications (30 day supply or less).

For maintenance medications (long-term), you are allowed one 30 day -fill only at any participating retail pharmacy. After the first 30 day fill, you must fill your prescription through the CVS Caremark Mail Service Pharmacy, CVS/pharmacy or other pharmacies that participate in the State of Connecticut Maintenance Drug Network.

ABOUT MAIL SERVICE and the STATE OF CONNECTICUT MAINTENANCE DRUG NETWORK

Where can I fill maintenance prescriptions?

The choice is yours. You can order 90-day supplies of maintenance medications at:

Mail Service: Register for mail service by phone (FastStart® toll free at 1-800-875-0867 from 8am -8:30pm Mon – Friday) or log on to www.caremark.com and sign in or register, if necessary. Have your Prescription Card number, the names of your medicines, your doctor's information and your payment information ready. We handle the rest.
CVS/pharmacy – Visit your local CVS/pharmacy. If you are currently using CVS/pharmacy to fill your maintenance medications, you can continue to do so. Your CVS/pharmacist can dispense your 90-day supply of a maintenance medication for one copay.
State of Connecticut Maintenance Drug Network – Fill your maintenance medications at a participating State of Connecticut Maintenance Drug Network Pharmacy. If your pharmacy is participating in the State of Connecticut Maintenance Drug network, you can use the pharmacy to dispense your 90-day supply of a maintenance medication.

How long does it take for my prescriptions to arrive by mail?

Please allow 7-10 days for delivery from the time the order is placed. You can check your refill status on-line or by calling toll-free at 1-800-318-2572. **Please note:** Mail order packaging accommodates all temperature sensitive drugs.

How should I ask my doctor or other prescriber to write my prescription in order to receive the maximum benefit for my maintenance medication?

Remind your doctor or other prescriber to write a "90-day supply plus refills," when clinically appropriate, for maintenance medications. CVS Caremark must fill your prescription for the exact quantity of medication that your doctor or healthcare provider prescribes, up to your plan design limit. When you need to take your maintenance medication right away, ask your doctor or other prescriber for two prescriptions:

- The **first** for up to a 30-day supply
- The **second** for up to a 90-day supply, with refills when clinically appropriate

Have the short-term supply filled immediately at any CVS Caremark participating retail pharmacy. Then you have the choice to fill your maintenance medication using Mail Service Pharmacy, CVS/pharmacy, or a pharmacy participating in the State of Connecticut Maintenance Drug Network.

ABOUT THE CVS CAREMARK DRUG LIST

What is a drug list?

It is a list of preferred prescription medications that have been chosen because of their clinical effectiveness and safety. This list is typically updated every three months. The drug list promotes the use of preferred brand-name medications and generic medications whenever possible. Generic medications are therapeutically equivalent to brand-name medications and must be approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness. Generally, generic medications cost less than brand-name medications. You can get a drug list by either visiting www.caremark.com or by calling Customer Care toll-free at 1-800-318-2572.

Where can I get a drug list brochure?

You can get a drug list brochure by visiting Caremark.com or by calling a Customer Care Representative toll-free at 1-800-318-2572. To save money, have your doctor or other prescriber choose a generic or preferred brand-name medication from the CVS Caremark Drug List, if appropriate. You may want to take the list with you when you visit your doctor or other prescriber.

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CVS CAREMARK

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.osc.ct.gov/anthemctpartner. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.cciio.cms.gov or call Anthem Blue Cross and Blue Shield at 1-800-922-2232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$350**/individual; **$1,400**/family-**waived for HEP members** Out-of-Network: **$300**/Individual; **$900**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Once you or a family member meets the individual deductible amount, the plan begins to pay for you or that family member. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary care and specialist office visits, preventive care, prescription drugs, emergency room care, urgent care, mental health and substance abuse outpatient services, and eye exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: **$2,000**/individual; **$4,000**/family Prescription drugs: $**4,600**/individual; $**9,200**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Out-of-network deductible and cost sharing, premiums, balance-billing charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.osc.ct.gov/anthemctpartner or call 1-800-922-2232 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copay** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge. Deductible does not apply.	$15 copay/visit. Waived if no in-state preferred provider. Deductible does not apply.	20% coinsurance	None.
	Specialist visit	No charge. Deductible does not apply.			
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Prior authorization required to avoid penalty: lesser of $500/20% of cost.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.osc.ct.gov/benefits/pharmacy.htm	Generic drugs	Preferred generic: Retail: $5 copay; Mail order & maintenance drugs: $5 copay. Non-preferred generic: Retail: $10 copay; Mail order & maintenance drugs: $10 copay		20% coinsurance for non-participating pharmacy	Retail: 30-day supply; Mail order: 90-day supply. Deductible does not apply to prescription drugs. Check details of your Rx coverage at: www.osc.ct.gov/benefits/pharmacy.htm. Maintenance drugs must be filled by mail order or by Maintenance Network pharmacy after first retail fill. Penalty may apply if brand name drug is requested when a generic is available. Some drugs require prior authorization. No charge for FDA-approved generic contraceptives (or brand name contraceptives if generic is medically inappropriate).
	Preferred brand drugs	Retail: $25 copay; Mail order & maintenance drugs: $25 copay.		20% coinsurance for non-participating pharmacy	
	Non-preferred brand drugs	Retail: $40 copay; Mail order & maintenance drugs: $40 copay.		20% coinsurance for non-participating pharmacy	
	Specialty drugs	Same as non-preferred brand drugs		Same as non-preferred brand drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Physician/surgeon fees	No charge			
If you need immediate medical attention	Emergency room care	$250 copay/visit. Deductible does not apply.		Same as in-network plus excess over allowed amount.	Copay waived if admitted.
	Emergency medical transportation	No charge		No charge	None.
	Urgent care	$15 copay/visit. Deductible does not apply.		20% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. No coverage in excess of cost of a semi-private room unless medically necessary.
	Physician/surgeon fees	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit. Deductible does not apply.		20% coinsurance	None.
	Inpatient services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you are pregnant	Office visits	$15 copay/first visit only. Deductible does not apply.		20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copay, coinsurance, or deductible may apply. Maternity care may include tests & services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge		20% coinsurance	Prior authorization required for stay in excess of 48 hours (96 hours for cesarean delivery) to avoid penalty of lesser of $500 or 20% of covered services.
	Childbirth/delivery facility services				

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge		20% coinsurance	Limit: 200 visits/calendar year.
	Rehabilitation services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. In-network speech therapy limit: 30 visits/calendar year. Limit does not apply to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of oropharynx. Out-of-network physical, occupational, chiropractic, speech & autism therapy limit: 30 visits/condition/calendar year.
	Habilitation services	No charge		20% coinsurance	None.
	Skilled nursing care	No charge		20% coinsurance	Out-of-network limit: 60 visits/ year/ person Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Durable medical equipment	No charge		20% coinsurance	Prior authorization required for items over $500 to avoid penalty of lesser of $500 or 20% of covered services.
	Hospice services	No charge		20% coinsurance	Inpatient services: prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. Out-of-network inpatient services limit: 60 days/person/calendar year. Out-of-network in-home services limit: 200 visits/calendar year

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 copay/visit. Deductible does not apply.		50% coinsurance	Limit: 1 visit/calendar year performed as part of an exam.
	Children's glasses	Not covered		Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered		Not covered	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Non-emergency care when traveling outside the United States (urgent care covered)
- Long-term care
- Routine foot care (except when medically necessary for treatment of diabetes)
- Weight loss programs (except as required by law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit: 20 visits per calendar year)
- Bariatric surgery (prior authorization required)
- Chiropractic care (limit: 30 visits per calendar year for out-of-network services)
- Hearing aids (limit: 1 set per 36 month period; prior authorization required)
- Infertility treatment (prior authorization required)
- Non-emergency care when traveling outside the United States (urgent care only)
- Private-duty nursing (prior authorization required)
- Routine eye care (adult, limit: 1 exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, CT 06492
1-800-922-2232

CVS/Caremark
Prescription Claim Appeals MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

Additionally, a consumer assistance program can help you file your appeal. Contact the Connecticut Office of the Health Care Advocate at 1-866-466-4446

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-800-922-2232.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-922-2232.
如果需要中文的帮助，请拨打这个号码1-800-922-2232.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-922-2232.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$350
Specialist copayment	$15
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copays	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$435**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$350
Specialist copayment	$15
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copays	$190
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$310**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$350
Specialist copayment	$15
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

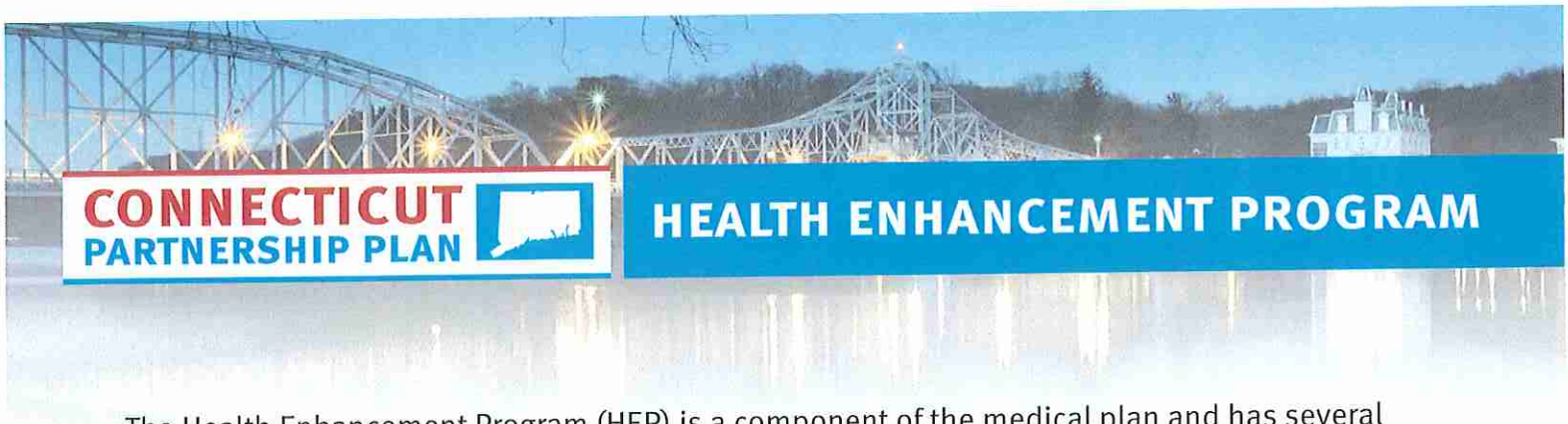
Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copays	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please visit http://osc.ct.gov/benefits.htm

The **plan** would be responsible for the other costs of these EXAMPLE covered services.



CONNECTICUT PARTNERSHIP PLAN

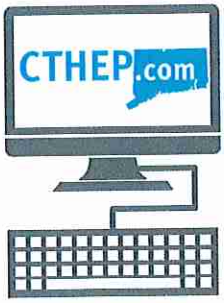
HEALTH ENHANCEMENT PROGRAM

The Health Enhancement Program (HEP) is a component of the medical plan and 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 healthcare. Third, it will save money for the Partnership Plan long term by focusing healthcare dollars on prevention.

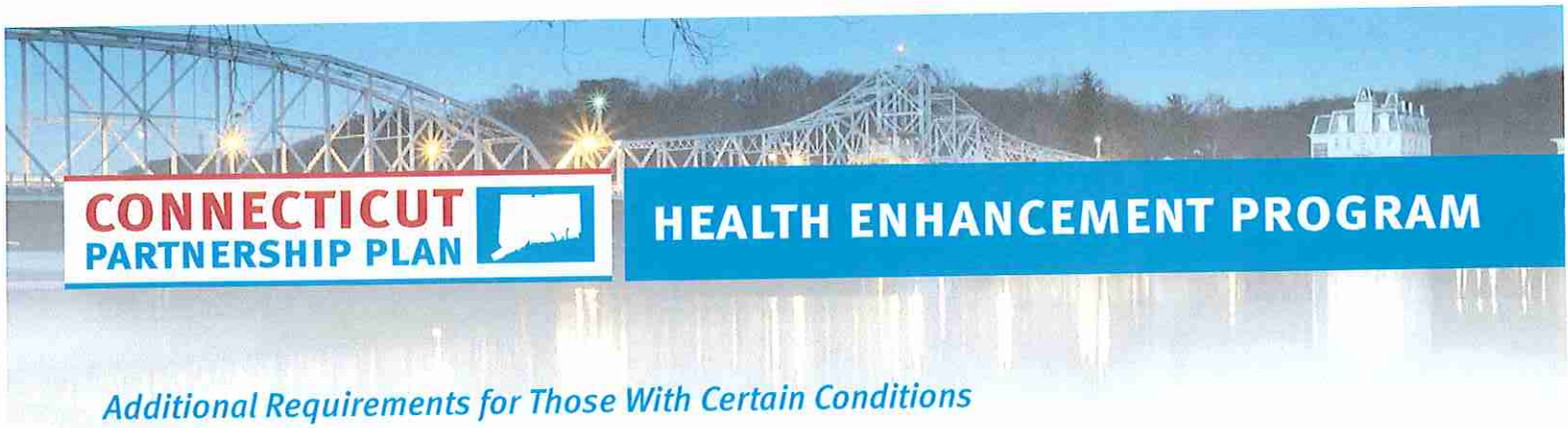
Health Enhancement Program Requirements

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). Here are the 2021 HEP 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 5 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	N/A	1 screening between age 45-49	As recommended by physician
Cervical Cancer Screening	N/A	N/A	Pap smear every 3 years (21+)	Pap smear every 3 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years, Annual FIT/ FOBT to age 75 or Cologuard screening every 3 years



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



Additional Requirements for Those With Certain Conditions

If you or any enrolled family member has 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 copays for treatments related to your condition.

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

If You Do Not Comply with the requirements of HEP

If you or any enrolled dependent becomes non-compliant in HEP, your premiums will be $100 per month higher and you will have an annual $350 per individual ($1,400 per family) in-network medical deductible.

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
(877) 687-1448 Monday – Thursday, 8:00 a.m. – 6:00 p.m. Friday, 8:00 a.m. – 5:00 p.m.

CARE
MANAGEMENT
SOLUTIONS®

Health Enhancement Program (HEP)



Welcome to the State of Connecticut Health Enhancement Program

Care Management Solutions Inc. (CMSI) administers HEP for the State of Connecticut Employees and Municipalities that join the partnership plan.



Purpose of HEP

To positively impact the overall health of its participants through two components: Preventive Requirements and Chronic Condition Education and Counseling

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How HEP Works

- All requirements and chronic condition education are measured per **calendar year**
- Preventive requirements are determined by **age and gender**
- Chronic conditions are determined through claims and medication history on an individual basis
- All requirements (preventive and chronic education) are to be completed by **December 31** of each year
- If you have joined HEP at any time after **January 1st** of the current year, you will have until the end of the following year to complete your requirements



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Preventive Requirements

HEP 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 5 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	N/A	1 screening between age 45-49**	As recommended by physician
Cervical Cancer Screening	N/A	N/A	Pap smear every 3 years (21+)	Pap smear every 3 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 5 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years, Annual FIT/FOBT to age 75 or Cologuard screening every 3 years

For those with a chronic condition: The household must meet all preventive and chronic requirements to be compliant.

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Chronic Condition Education and Counseling

The HEP program requires participants who have been identified with one or more of the following chronic conditions to complete annual educational requirements related to their disease, as well as accept a call from a CMSI registered nurse if one should reach out:

- Diabetes (Type 1 or 2)
- Asthma
- COPD
- Heart Disease/Heart Failure
- Hyperlipidemia
- Hypertension

All educational materials can be found at **CTHEP.com**



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Benefits of HEP

HEP does not only benefit your health, it also rewards employees and their dependents with a number of financial benefits by remaining compliant with the program:

- Lower premium payments – Non-HEP employees pay an additional **$100 per month in premium**
- Lower out-of-pocket expenses – Non-HEP employees pay **annual $350 individual/$1,400 family** in-network medical deductible
- Office visit co-pays are **waived** for anything related to the chronic conditions
- **Lower to $0 co-pays** for medications used to treat any of the chronic conditions mentioned earlier



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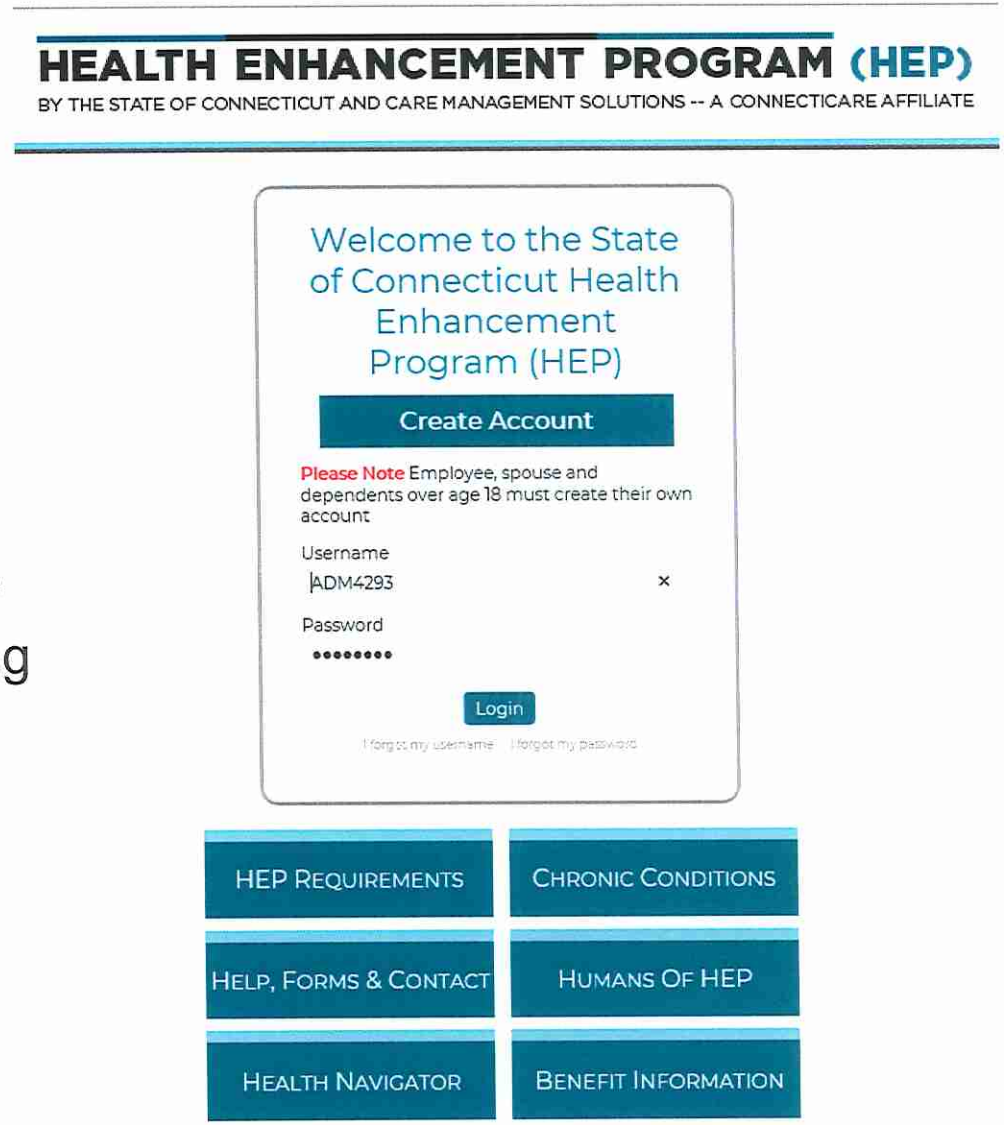
Register Online

- Online portal access will be available approximately **two months** after your effective date
- You can access information using the links below the login screen before you register
- Register at **CTHEP.com**



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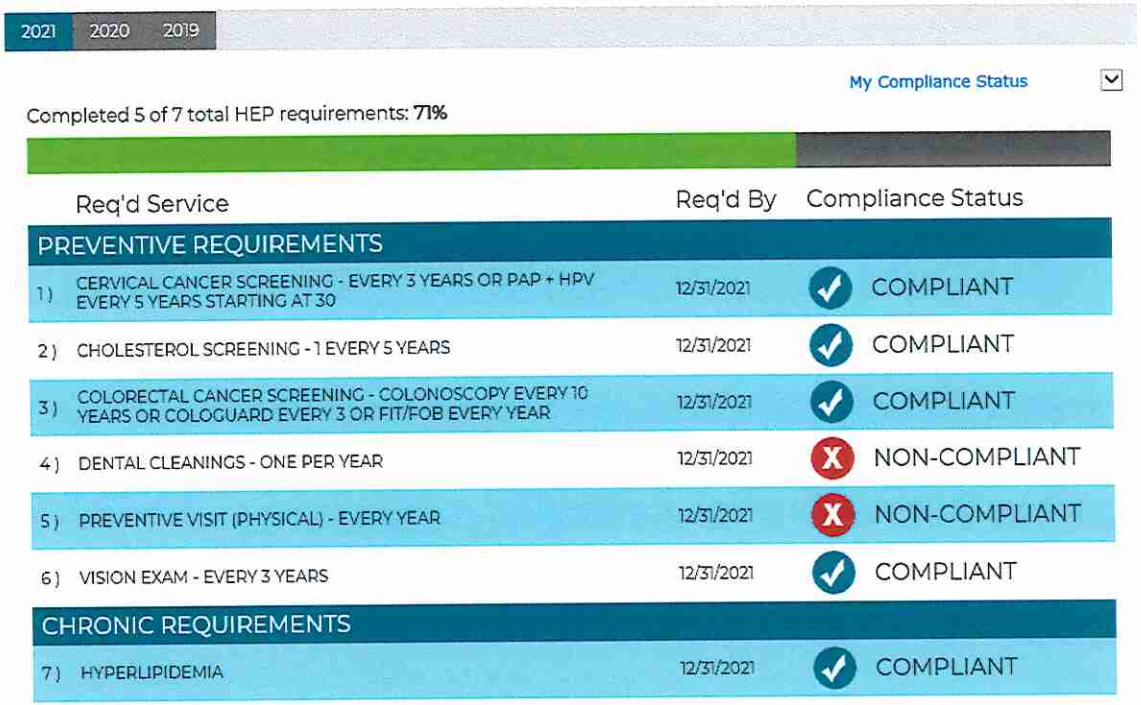
View Your Personal Requirements via the Web Portal

Once registered, you can:

- Check your compliance status
- Click on the "My Compliance Status" drop-down to check your family status
- If identified with a chronic condition, click "fix this" to take a 5 question survey or read a fact sheet to complete the requirement online



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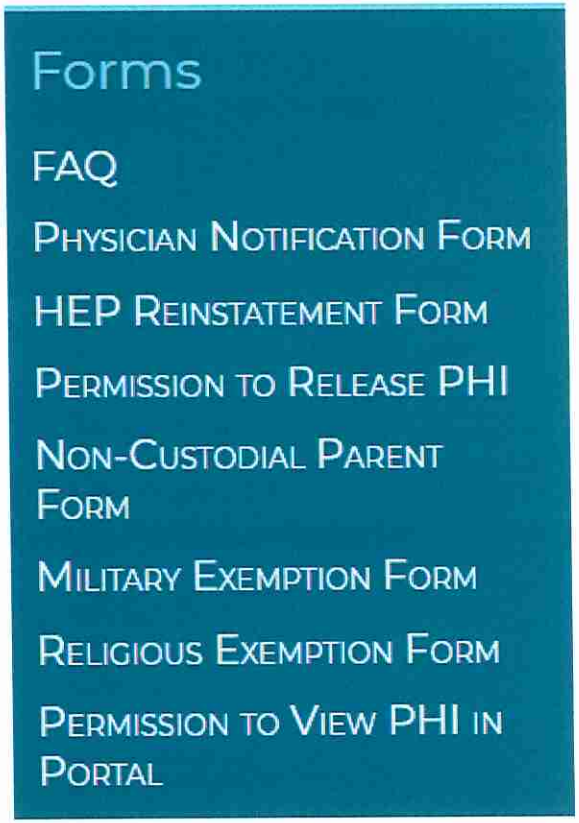
Help, Forms & Contacts

- Under **Help, Forms & Contacts** you can locate our most commonly used forms. The **Physician Notification Form** should be used when a service was preformed prior to joining your new plan.

- Please have your physician fill it out and you can fax it back to us - **1.855.207.1640.**

- We have added an **FAQ** document on the program with many helpful resources, should you have any questions



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Questions or Concerns?

Contact our call center to receive guided support at **1.877.687.1448**
Monday-Thursday 8am – 6pm and Friday 8am – 5pm

You can also contact a customer service representative via email at **HEPQuestions@Connect2YourHealth.com.**

Fax number: 855-207-1640

You can log onto **CTHEP.com** and register 60 days from your insurance effective date



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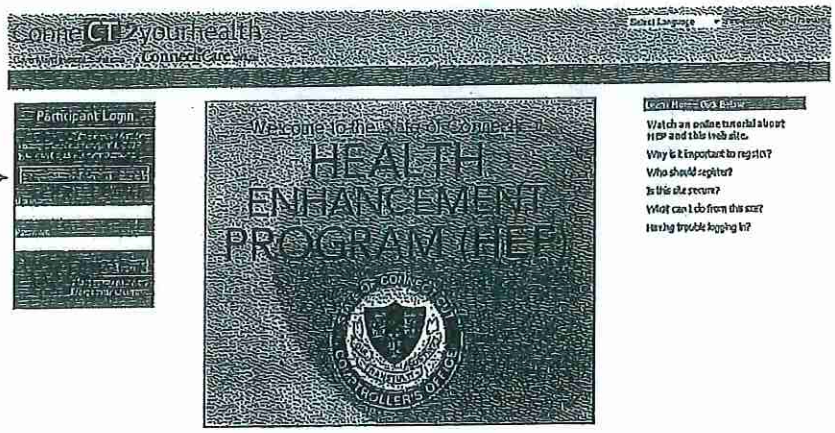
Access your HEP Information anytime through your CUSTOMIZED & SECURE participant portal

Get started by going to www.CTHEP.com and following the simple STEPS below

Begin by Creating a New Account →



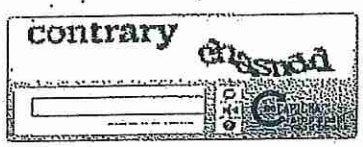
Step 1: Enter Your Identification

Employee, spouse and dependents over age 18 each must create their own account. Please begin by entering the last four digits of the social security number of the enrolled employee. Then enter YOUR first and last name, date of birth, and the zip code of your home address. Finish step 1 by entering the security phrase below.

Last 4 digits of Employee SSN:

Your First Name: Your Last Name:

Date of Birth: (mm/dd/yyyy): Zip:



If you are having trouble, click the refresh button

To learn about why this security process is important, please click the question mark in the box above.

Cancel Next Step

Step 2: Set-up Your Account Information

To Create your new account, please enter a username and password. Passwords must be 6-20 characters and contain one number and one capital letter.
If the email field is already filled in, please confirm it is your correct personal email address. If it is incorrect, or if there is no email address filled in, please add and confirm a personal email address now.

Username:

Password:

Must be 6-20 characters and contain one number and one capital letter

Confirm Password:

Personal Email:

Confirm Email:

☐ I do not have an email address.

Cancel Next Step

Step 3: Respond to Security Questions

Please select two questions below and enter your answers for future reference. You will be asked these questions when requesting a forgotten username or password. You must select two different questions and supply two distinct answers.

Question 1:
Select ...
Answer:

Question 2:
Select ...
Answer:

Cancel Change



Anthem

Simple, smart — and all about you

Get instant access to your health plan info at anthem.com or with Sydney, our new app

Check claims
See what's covered and what you owe.

Find a doctor
Look for doctors in your plan.

Get discounts
Save on health-related products and services.

See benefits
Check what your plan covers and how much you might pay.

Get medicine
Refill your prescriptions online.

Manage health care accounts
Pay or reimburse yourself for health care expenses. See your account balance anytime.

Get your ID card
Share, fax or email your ID card right from your device.

Estimate costs
Compare costs and quality for common procedures.

It's easy. Everything you need to know about your Anthem benefits — all in one place. It's simple, personal and all about you.

You can do more in less time — just log in at anthem.com.
Don't forget: You can have your health information at your fingertips anytime through the Sydney mobile app.

GET IT ON Google Play

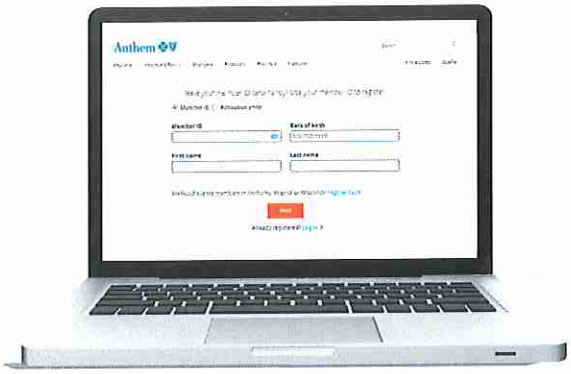
Download on the App Store

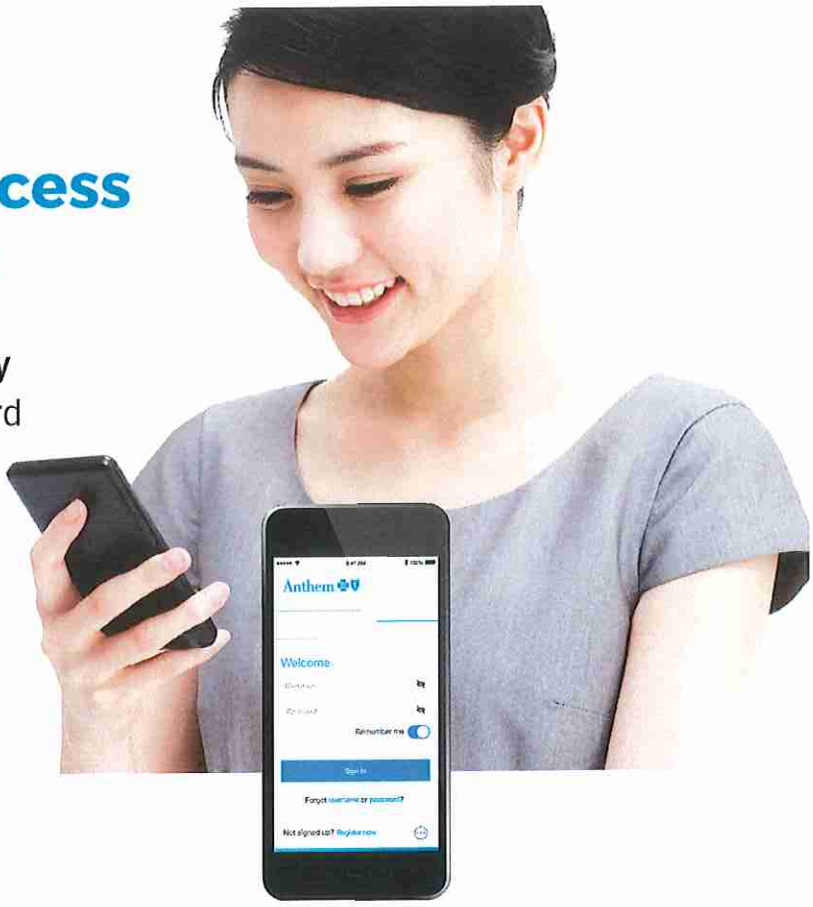
Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

23882MUMENABS VPOD Rev. 06/19

You've got quick access to your health care!

Register on **anthem.com** or the **Sydney** mobile app.* Have your member ID card handy to register





From your computer

1. Go to **anthem.com/register**
2. Provide the information requested
3. Create a username and password
4. Set your email preferences
5. Follow the prompts to complete your registration

From your mobile device

1. Download the free **Sydney** mobile app and select **Register**
2. Confirm your identity
3. Create a username and password
4. Confirm your email preferences
5. Follow the prompts to complete your registration

It's easy. Everything you need to know about your plan — including medical — in one place. Making your health care journey simple, personal — all about you.

Need help signing up?
Call us at **1-866-755-2680**.

Anthem

* You must be 18 years or older to register your own account.

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CARE COMPASS

OFFICE *of the* STATE COMPTROLLER



For injuries from head to toe- Upswing it!

Use Upswing when hip, knee or shoulder pain keeps you up night after night, when you suddenly throw your back out or when a nagging injury from the past is slowing you down.

Search injury → Talk with a professional → Follow care advice

- Receive guidance on how to treat minor injuries at home, for example, how to treat a sprained ankle, sudden back spasm, or a pulled muscle.
- Consult with a doctor via telemedicine visit.
- Get a custom, video-based rehab/exercise program emailed directly to you.
- Help expedite your care with a referral to a physician for further, in-person evaluation or testing if needed.
- Personalized follow-up with a health coach to check on your progress and recovery.

A health coach will respond quickly when you set up a chat request between the hours of 8 am – 8 pm, 7 days a week.

Visit Upswing Health today!

UPSWING HEALTH

For any non-emergency orthopedic injury including tendinitis, sprains, Carpal Tunnel Syndrome, arthritis and more.

Need help getting started?
Call Upswing: (203) 204-3855
Email: info@upswinghealth.com

Use **Upswing Health** to learn what's causing your joint pain, and, if you'd like, connect to a live health coach without leaving your home.

For urgent injury situations:
A Health Navigator nurse is available 24/7 to evaluate your symptoms, advise care, and locate the nearest Orthopedic Urgent Care Center in your area when necessary. **Call Health Navigator: 1-866-611-8005**

For more information, click on the Health Navigator logo below

Visit Care Compass | follow on facebook

HEALTH NAVIGATOR

Cigna Healthcare Financial Exhibit for:

New London Public Schools

Effective Date: July 01, 2016



This is a summary of benefits for your dental plan. All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

State of Connecticut Network Benefits	Cigna Dental PPO	
	In-Network	Out-of-Network
Calendar Year Maximum		
(Class I, II, III Expenses)	$1,500, Class I Applies No calendar year max for Periodontal Maintenance & Periodontal Scaling & Root Planing	$1,500, Class I Applies
Calendar Year Deductible		
Per Individual	$0	$0
Per Family	$0	$0
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-Rays Non-Routine X-Rays Fluoride Sealants Space Maintainers (limited to non-orthodontic treatment) Brush Biopsy	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Fillings Emergency Care to Relieve Pain Oral Surgery - Simple Extractions Oral Surgery- All Except Simple Extraction Surgical Extraction of Impacted teeth Anesthesia Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Periodontics	80%, No Deductible	80%, No Deductible
Class III Expenses - Major Restorative Care		
Crowns / Inlays / Onlays Prosthesis over Implant Stainless Steel/Resin Crowns Bridges Dentures	67%, No Deductible	67%, No Deductible
Class IV Expenses - Orthodontia		
Coverage for Children until age 19 Lifetime Maximum	50%, No Ortho Deductible $1500	50%, No Ortho Deductible $1500
Class VI Expenses - Periodontics		
Periodontal Maintenance Periodontal Scaling and Root Planing	80% No Deductible No Maximum	80% No Deductible No Maximum
Missing Tooth Provision	No limitation	
Late Entrant Limit	No coverage until next open enrollment	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed.	
Out-of-Network Reimbursement	Based on 95th percentile of Reasonable and Customary Rates	
Student/Dependent Age	26/26	

CP011 (NS001 DNSP) Network.

Cigna Healthcare Financial Exhibit for:

New London Public Schools

Effective Date: July 01, 2016

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two routine and two periodontal cleanings per calendar year
Fluoride	2 per calendar year for people under 16
X-Rays (routine)	Bitewings: 1 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 5 calendar year. Panorex: 1 every 5 calendar year
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service, Frequency limit of once per 24 months
Perio Surgery	Various limitations depending on the service, Frequency limit of once per 36 months
Crowns and Inlays	Replacement every 7 years
Prosthesis Over Implants	1 per every 7 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	Replacement every 7 years
Dentures and Partials	Replacement every 7 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 16
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within seven years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting
* Instruction for plaque control, oral hygiene and diet
* Implants
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

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Website Tools:
- manage claims
- view balances and maximums tracker
- Find a dentist
- Print dental ID cards
- Request a new dental card

Cigna.

LOGIN / REGISTER

Login to myCigna.com

User ID

Please enter your User ID

Password

Please enter a valid password

LOGIN

Forgot User ID | Forgot Password | Login Help

Don't have a user ID and Password?

REGISTER NOW REGISTRARSE EN ESPAÑOL

Registering to take the Health Assessment?
If you or your dependent(s) are registering to take the Health Assessment, each person must register separately and then log in with their own User ID and Password.

¿Está buscando myCigna en español? **Obtenga más información.**

Not sure which site to use? ›› **Other Cigna Websites & myCigna Capabilities**

New 1-touch log-in to myCigna

Now with fingerprint access, the myCigna app makes it easier than ever to stay in-network—and save. Download the app today.

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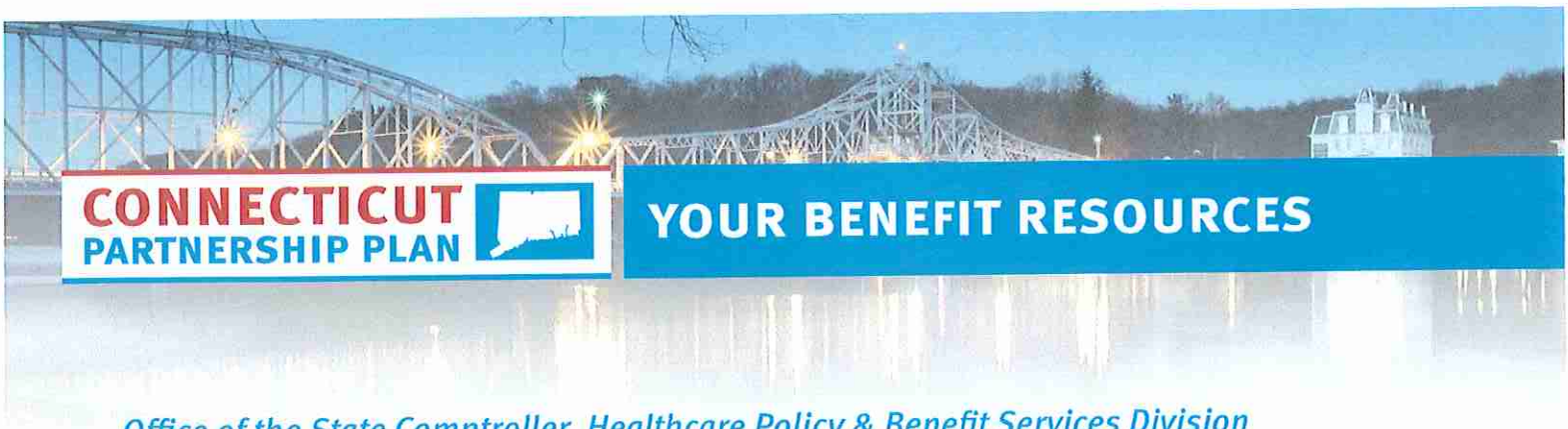

YOUR BENEFIT RESOURCES

Office of the State Comptroller, Healthcare Policy & Benefit Services Division

www.osc.ct.gov/ctpartner
860-702-3560

Anthem Blue Cross and Blue Shield

www.anthem.com/statect
Enhanced Dedicated Member Services: ***1-800-922-2232***

Caremark (Prescription drug benefits)

www.caremark.com
1-800-318-2572

CIGNA (Dental and Vision Rider benefits)

www.cigna.com/stateofct
1-800-244-6224

Health Enhancement Program (HEP) Care Management Solutions (an affiliate of ConnectiCare)

www.cthep.com
1-877-687-1448

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 Payroll/Human Resources office.

CARE COMPASS

OFFICE *of the* STATE COMPTROLLER



Anthem's Sydney Health App

Find doctors and locations in your network, including *Network of Distinction* providers. Get help when needed with a virtual doctor visit with LiveHealthonline - a $5 copay required per medical or psychiatry visit. Look up your digital ID card for valuable information when you need it. Stay current with your benefits and claims details. Sync to your fitness tracker and set reminders to help you stay on track with your wellness goals.

myCigna App

Locate a dentist within minutes, tap to call and set up your annual dental cleaning. Update your contact information and notification preferences so you can stay current with your plan details. View a list of your most recent claims, their status, and reimbursements.

CVS Caremark App

Quickly refill a prescription or check on an existing order. Find a nearby pharmacy. Easily show providers your digital ID card or medication list in just one click. Check drug costs and get advice about money-saving generic alternatives. For medications taken regularly, order a 90-day supply which typically costs less than a 30-day supply. Check drug interactions, identify unknown pills, or set up automatic refills to help your medication work best for you.

Visit Care Compass | **follow on facebook**

Health Care in the Palm of Your Hand

Access care, tools & resources all on your smartphone...

Download the Anthem, Cigna and CVS mobile apps to make your health care benefits more convenient.







For all your Benefit needs call **Health Navigator** at:
1-866-611-8005
or click on the Health Navigator logo below:

HEALTH NAVIGATOR

New London Public Schools



More, for less...

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Hello, Neighbor

- You're on the INSIGHT Network
- For a complete list of providers near you, use our Provider Locator on www.eyemed.com and choose the INSIGHT network or call 1-866-804-0982.
- For Lasik providers, call 1-877-5LASER6 or visit eyemedlasik.com.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $110 allowance; 80% of charge over $110	Up to $77
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Standard Progressive Lens	$90 Copay	Up to $50
Premium Progressive Lens△	$110 Copay - $135 Copay	
Tier 1	$110 Copay	Up to $50
Tier 2	$120 Copay	Up to $50
Tier 3	$135 Copay	Up to $50
Tier 4	$90 COpay, 80% of charge less $120 Allowance	Up to $50
Lenticular	$25 Copay	Up to $70
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$0	Up to $32
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating△	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses		
Conventional	$0 Copay; $110 allowance; 15% off retail price over $110	Up to $110
Disposable	$0 Copay; $110 allowance; plus balance over $110	Up to $110
Medically Necessary	$0 copay, Paid in Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

△Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels.

eyemed

What's in it for me?

Options. It's simple really. We love our members–that's why we are dedicated to helping you see clearly and we've built a network that gives you lots of choices and flexibility. You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy to use and to save you money. Welcome to EyeMed.

eyemed.com

Benefits Snapshot	With Us	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	$10 Copay	Up to $40
Frames (Once every 12 months)	$0 Copay; $110 allowance; 80% of charge over $110	Up to $77
Single Vision Lenses (Once every 12 months)	$25 Copay	Up to $30
Or		
Contacts (Once every 12 months)	$0 Copay; $110 allowance; plus balance over $110	Up to $110

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference . . .

73% SAVINGS with us

With Us		Without Insurance**	
Exam	$10 Copay	Exam	$106
Frame	$163 -$110 allowance $53 -$10.60 (20% discount off balance) $42.40	Frame	$163
Lens	$25 Copay $15 UV treatment add-on +$15 Scratch coating add-on $55	Lens	$78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total	$107.40	Total	$395

Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. **Based on industry averages.

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New benefits - Overview

Vision - EyeMed

Vision Care Services	**Member cost in-network**
Frequency	Once every 12 months
Eye exam	$10.00 co-pay
Retinal Imaging	Up to $39.00
Frames	$110 allowance, 20% off balance over $110
Standard Lenses	$25.00 co-pay
Premium Progressive	$40.00 co-pay
Treated Lenses	
UV Treatment	$15.00 co-pay
Tint	$15.00 co-pay
Scratch coating	$15.00 co-pay
Contact Lenses	
Conventional	$0.00 co-pay, $110.00 allowance, 15% off balance over $110
Disposable	$0.00 co-pay, $110.00 allowance, plus balance over $110
Medically necessary	$0.00 co-pay. Paid in full
Laser Vision Correction	15% off retail price or 5% off promotional price

Monthly Rate	Monthly	Bi-weekly rate
Employee only	$5.68	$2.84
Employee +1	$10.78	$5.39
Family	$15.84	$7.92

Got Questions? We Can Help!

Your Questions Answered

Q: My eyes are fine. Do I really need to have them checked regularly?

A: Yes, regular eye exams are the way to go. It's not just about correcting your vision—it's about overall health. Eye exams can spot health conditions—like glaucoma, diabetes, cataracts and hypertension—early. The sooner these issues are spotted, the sooner you can get treatment.

Q: Will I save more money with this vision care benefit, or with an eyewear coupon or other promotional offer?

A: Great question! There are lots of special offers and coupons out there. When you compare them to your plan coverage, you'll likely find that your vision plan saves you more money in almost every case. A nice bonus is that you can use your vision benefit whenever you need to. Say goodbye to coupon expiration dates and limited time offers.

Keep in mind that your benefit can't be combined with any other discounts or promotional offers. Naturally, you're responsible for copays, any remaining out-of-pocket expenses and applicable sales tax.

Q: How do I get in touch with the Customer Care Center?

A: It's easy! You can talk to a representative—a real person—by calling 866-939-3633. Also, you'll find automated features online at www.eyemedvisioncare.com or through our automated voice response system.

Hours of live operation:
Monday – Saturday: 7:30 a.m. to 11:00 p.m. EST
Sunday: 11:00 a.m. to 8:00 p.m. EST

Q: I'm already enrolled in EyeMed through my spouse, can I join this plan too?

A: Sure, you can enroll on both plans! Just remember, you won't be able to combine your benefits in the same transaction.

For overall wellness, don't forget your annual eye exam.

Visit us on line at EyeMed.com to learn more

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Got Questions? We Can Help!

Your Questions Answered

Q: Can I book an appointment online?

A: Absolutely! Go to www.eyemedvisioncare.com and click on "Find a Provider." Enter your zip code, select your network, and click "Get Results." From there, you can book an appointment with providers that offer online scheduling. How easy is that?

Q: Can I get new contacts and glasses in the same year?

A: Every 12 months, you can get either contacts or spectacle lenses. And you're welcome to update your look with new frames every 12 months.

Q: Do I need to have my ID card with me to use my benefits?

A: Nope. An in-network provider only needs your name and date of birth. How easy is that?

Q: How do I get another member ID card?

A: If your member ID card gets lost, no worries! You don't even need one to receive service. But if you want an additional card, you can request it through our website www.eyemedvisioncare.com.

Q: What's included in a covered exam? Is dilation an extra cost?

A: No worries, we've got you covered. Eye exams at participating providers include dilation and other important eye health tests. There are no added out-of-pocket costs (other than a copay, if applicable).

Q: How does the standard lens benefit work?

A: It's simple. We give you a standard, plastic lens – either single vision or lined multifocal – as part of the covered benefit. You're only responsible for a copay, if applicable, and taxes.

Q: What about "add-ons" to the standard lenses?

A: Want UV and scratch protection? Or any anti-reflective coatings? Good news! Most of these common "add-ons" are discounted at EyeMed providers. Check with your provider before ordering for details.

There is so much to see. Give your eyes a front-row seat.

Visit us on line at EyeMed.com to learn more

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Got Questions? We Can Help!

Your Questions Answered

Q: Can I receive no-line bifocals as part of the lens benefit?

A: Absolutely. EyeMed also offers set pricing on standard progressive (no-line) lenses. All you're responsible for is a $65 amount, plus the standard lens copay and taxes. Also, some plans offer set pricing on premium progressive lenses based on the lens brand.

Q: Does my allowance amount only apply to certain frames?

A: No, you're free to apply your allowance toward the retail price of ANY frame at any in-network location. EyeMed also gives you a 20% discount on the difference between the retail price and your allowance amount.

Q: How does the contact lens benefit work?

A: Just like the frame allowance, the contact allowance is applied to the retail price of any contact lens. No fussy formularies to worry about! Also, you can apply a 15% discount to the difference between the retail price and the allowance amount for non-disposable contacts.

Q: What is a contact fitting?

A: After buying contacts, a provider may ask you to check back in – just to make sure they're perfect for you. They will assess your eyes and ensure that the new contacts are a great fit.

Q: Can I carry over an unused allowance amount to another purchase?

A: Sorry, the contact allowance amount is a one-time allowance. It's best to use the full benefit on your initial purchase of contacts.

Q: Do I need to pay the full retail price for non-covered items?

A: You have a 20% discount to buy items not covered by the plan at network providers. This discount applies to everything except professional services and contact lenses.

Seeing life's beauty.

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Got Questions? We Can Help!

Your Questions Answered

Q: Do I need to submit claims for services rendered at an in-network provider?

A: Not at all. If you visit an EyeMed participating provider, you don't need to worry about filling out forms or vouchers to get your benefits. After collecting the appropriate copays and other out-of-pocket expenses at the time of service, the provider submits the claim to EyeMed on your behalf.

Q: Does EyeMed offer any additional discounts?

A: Yes, indeed! You can enjoy these additional savings with a funded EyeMed plan:

- 40% off additional complete pairs of glasses.
- 20% off any remaining frame balance.
- 20% off non-covered items, including non-prescription sunglasses, accessories and lens cleaner.
- 15% off any remaining conventional contact lens balance.
- 15% off the standard price or 5% off promotional price of LASIK or PRK services.

Q: Do members have to go to a participating provider?

A: No restrictions here. You have the freedom to choose non-participating providers. But please keep in mind that you can make the most of your benefit – and save money – by choosing an in-network provider. We make it convenient and easy to find one - which is why 95% of members visit in-network. Use our Smart Locator on eyemed.com to find providers near you!

At non-participating providers you must pay full out-of-pocket pricing at the time of service. Then you can submit a claim to First American Administrators for reimbursement of covered services

EyeMed offers benefits to meet your lifestyle.

Visit us on line at EyeMed.com to learn more

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Got Questions? We Can Help!

Your Questions Answered

Q: Who qualifies for "medically necessary" contact lenses?

A: Members who are diagnosed with any of the following:

- Anisometropia of 3D in meridian powers.
- High Ametropia exceeding 10D or +10D in meridian powers.
- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement other than keratoconus for members whose vision can be corrected by two lines on the visual acuity chart when compared to the best corrected standard spectacle lenses.

Seem confusing? Our award-winning service center is always available to answer tough questions.

Q: Does your provider network include both independent and optical retailers?

A: Yes. Members can choose from thousands of private practitioners and the nation's leading optical retailers: LensCrafters®, Target Optical®, JCPenney Optical®, Sears Optical®, and most Pearle Vision® locations.

And if your favorite provider isn't in our network yet, you can nominate it. Just complete a Provider Nomination Form available through EyeMed's Customer Care Center. The provider must accept and agree to the Terms and Conditions of our Professional Provider Agreement and complete the credentialing process to ensure they meet EyeMed's quality standards.

Seeing life to the fullest.

Visit us on line at EyeMed.com to learn more

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Got Questions? We Can Help!

Your Questions Answered

Q: Do you offer a discount on laser vision correction?

A: You bet we do. Members get 5% off any promotion or 15% off the retail price for treatments performed through the U.S. Laser Network, which is owned and administered by LCA-Vision.

Q: How do I access the laser vision discount?

A: Follow these simple steps to get the ball rolling:

1. First, pick which laser correction provider you'd like to use. Call the U.S. Laser Network at 1-877-5LASER6 for a complete list.
2. Next, set up a consultation with the provider. When making the appointment, be sure to tell them you're an EyeMed member.
3. The consultation is next. That's when you and your provider will decide whether or not you're a good candidate for the procedure. Be sure to bring questions.
4. Going ahead with laser correction? Great! Call the U.S. Laser Network to request an authorization for your discount. At this time, you'll also need to put down a refundable deposit. The authorization will be sent to you and the laser provider.
5. All that's left is scheduling your procedure. After surgery, be sure to follow all post-operative instructions carefully. Then treat your new eyes to a beautiful view.

Seeing life's treasures.

Visit us on line at EyeMed.com to learn more

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EXPERIENCE MORE: ONLINE ACCESS

HOW TO: enjoy your own eye site

MEMBER WEB ON EYEMED.COM

Your vision plan is like a friendly smile – it doesn't do any good if it's hidden away. Member Web at eyemed.com is here, there and everywhere. It's your vision plan control center. A place to manage the details of every visit and every claim. Instantly. Easily. Smile-ly.

START MANAGING YOUR BENEFITS IN A FEW EASY STEPS:

1. Visit eyemed.com and click on Member Login.
2. If you're a new user, click on Create an Account.
3. Register using your member ID or the last four digits of your social security number.* (You'll get an email asking to confirm your account.)
4. Finish setting up your new account with your email address and a password. (To keep it secure, we list some password "musts.")
5. Come back anytime to change your password, email address and billing preferences. (It's all under Manage Profiles.)

LOG IN 24/7 TO:

- View your benefit details
- Confirm eligibility
- Check claim status
- Print replacement ID cards
- Locate a provider
- Schedule an appointment online**
- View health and wellness information
- Get special offers

SEE THE GOOD STUFF

Register on EYEMED.COM or grab the member app (iTunes or Android) now.



Depends on how your benefit administrator entered you into the system.
**Most, but not all, network providers offer this.*

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PDF-1605-M-211

EXPERIENCE MORE: MOBILE ACCESS

HOW TO: mobilize your vision plan

EYEMED MEMBER APP

EyeMed's member app was the first of its kind. But innovation – like your life – never stops. Our app is packed with ahead-of-the-game resources wherever you are. Before, during and after your eye appointment.

Get the latest EyeMed member app:

1. DOWNLOAD – Search "EyeMed Members" in your App store, iTunes or Google Play.
2. OPEN – You can use some features right away; others unlock once you register.
3. REGISTER – You'll need your member ID or the last four digits of your social security number.
4. LOG IN – If you've already registered on eyemed.com, you can log onto the app the same way.

	Ready when you download	Unlocked when you register
Find nearby network providers	●	
On-the-fly appointment scheduling	●	
Turn by turn directions and map	●	
Eye exam and contact lens reminders		●
Electronic ID card for office visits		●
Vision prescriptions for everyone on your plan*		●
Benefit plan details		●
Answers to common questions	●	
Special offers and discounts		●
Direct line to EyeMed support	●	

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Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

New London Public Schools
Benefits Enrollment Form

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. You may only elect and will be covered for levels of coverage included in your employer's contract.
- **Step 2:** Please **sign, date and return** this form to Danielle Henderson in the Business Office. Do not mail this form back to The Hartford's address indicated at the top of this form.

Information About You	
Employee Name:	**Employee ID (if not available, then Social Security Number):**
Date of Birth:	
Date of Hire:	

Voluntary Long Term Disability Insurance

If coverage amounts are based on earnings, your cost may change if your earnings change. Your cost may also change when you move into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0600	0.0900	0.2100	0.2800	0.2700	0.3850	0.5050	0.5850	0.4550	0.4500	0.4500	0.4500

To calculate your semi-monthly cost, please use the following formula(s):

_____ ÷ 12 = _____ ÷ 100 = _____ x _____ = $_____

Your Annual Earnings Maximum = $100,000.00 | Your Monthly Earnings | Rate | Semi-monthly Cost

☐ I elect to **purchase** long term disability coverage.
☐ I **decline** to purchase long term disability coverage.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is

Name: _____

satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits may be changed by the insurer.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

Fraud Notice(s)
For Residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Louisiana and Maryland:
Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York (Not applicable to Life Insurance):
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed_____ Date_____

Group Benefits from The Hartford

Voluntary Long Term Disability Insurance



Benefit Highlights

New London Public Schools

What is Voluntary Long Term Disability Insurance?	Voluntary Long Term Disability Insurance pays you a portion of your Earnings if you miss time at work because of a disabling illness or injury. This highlight sheet is an overview of your Voluntary Long Term Disability Insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.
What is disability?	Disability is defined in The Hartford's contract with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical conditions covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings. Once you have been disabled for 24 months, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are less than 80% of your pre-disability earnings.
Am I eligible?	You are eligible if you are an active salaried employee who is determined by your employer to be eligible for benefits.
How much coverage would I have?	You may purchase coverage that pays you a benefit of 60% of your Earnings to a maximum monthly benefit of $5,000 per month. This plan includes a minimum benefit of the greater of: 10% of the benefit based on monthly income loss before the deduction of other income benefits or $100 per month. Earnings are defined as in The Hartford's contract with your employer.
When can I enroll?	You can enroll during your scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of your eligibility waiting period as stated in your group policy.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
How long do I have to wait before I can receive my benefit?	You must be disabled for at least 90 days before you can receive a Voluntary Long Term Disability Insurance benefit payment.

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Are there other limitations to enrollment?	The guaranteed issue amount is the amount of insurance that you may elect without providing evidence of insurability. If you elect coverage during your initial enrollment period or if this is the first time you are eligible to elect coverage, evidence of insurability is not required. Outside your initial enrollment period and during a family status change period, evidence of insurability is required to elect coverage for the first time. This coverage, like most group benefit insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.
Can the duration or amount of my benefit be reduced?	Yes. Your benefit duration may be reduced once you reach certain ages as specified in The Hartford's contract with your employer. In addition, as described below within the important details, your monthly long-term benefit may be reduced by other income you receive.
How long will my disability payments continue?	If you become disabled prior to age 63, benefits may continue for as long as you remain disabled or until you reach your Social Security normal retirement age. If your disability occurs at age 63 or above, the number of payments may reduce.

Important Details
The following is an overview of your Voluntary Long Term Disability Insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

Exclusions:
You cannot receive Voluntary Long Term Disability Insurance benefit payments for disabilities that are caused or contributed to by:

- war or act of war (declared or not)
- the commission of, or attempt to commit a felony
- an intentionally self-inflicted injury
- any case where your being engaged in an illegal occupation was a contributing cause to your disability

You must be under the regular care of a physician to receive benefits.

Mental Illness, Alcoholism and Substance Abuse:

- You can receive benefit payments for long-term disabilities resulting from mental illness, alcoholism and substance abuse for a total of 24 months for all disability periods during your lifetime.
- Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months lifetime limit.

Pre-existing Conditions:
Your insurance limits the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your policy, you will be covered for a disability due to that condition only if:

- you have not received treatment for your condition for the length of time specified in the contract before the effective date of your insurance, or
- you have been insured under this coverage for the length of time specified in the contract prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
- you have already satisfied the pre-existing condition requirement of your previous insurer.

Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security disability insurance (please see next section for exceptions)
- workers' compensation
- other employer-based insurance coverage you may have
- unemployment benefits
- settlements or judgments for income loss
- retirement benefits that your employer fully or partially pays for (such as a pension plan)

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Your benefit payments will not be reduced by certain kinds of other income, such as:

- retirement benefits if you were already receiving them before you became disabled
- retirement benefits that are funded by your after-tax contributions
- your personal savings, investments, IRAs or Keoghs
- profit-sharing
- most personal disability policies
- Social Security increases

This benefit highlights sheet is an overview of the Voluntary Long Term Disability Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

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Who is OMNI?

What does OMNI do?

Your employer has hired The OMNI Group to administer their 403(b) plan in accordance with applicable IRS regulations.

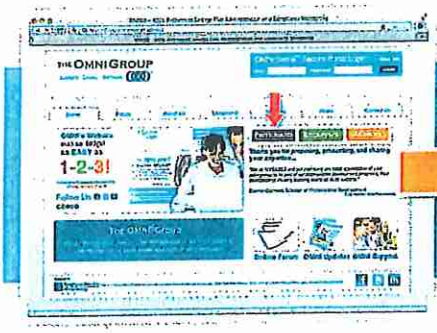
What does OMNI do for YOU?

> Ensure you do not exceed your Contribution Limit
> Process changes to your contributions
> Process Plan transaction requests (loans, hardships, rollovers, etc.)

How do you start a 403(b) Retirement Saving Account? 4 simple steps

Step 1:

Go to your employer's webpage on our website, http://www.omni403b.com and select the "Participants" button.



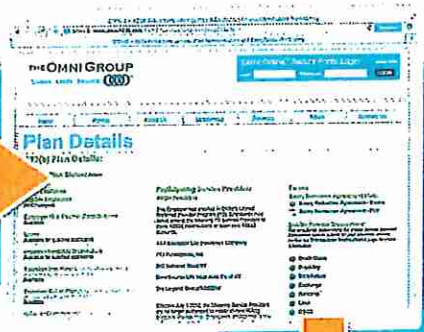
Step 2:

Select your state, type in name of your employer in the "Employer Plan Info." Box and click "Show Details":



Step 3:

Choose your Service Provider & Open your account*



Step 4:

Submit an SRA to OMNI



2014 403(b) Plan Limits

$17,500 Base Limit

Is employee eligible for 15-year cap expansion?

YES		NO	
$20,500 *Limit		**$17,500 Limit**	
Is employee age 50 or older this calendar year		Is employee age 50 or older this calendar year	
YES	NO	YES	NO
$26,000 *Limit	$20,500 *Limit	$23,000 Limit	$17,500 Limit

*Individual Calculations Required

*OMNI cannot provide advice concerning any particular service provider or investment vehicle. You may wish to consult with a financial advisor to determine which one(s) best meets your financial needs/goals.

Questions? Our Customer Care Center is available toll-free at 877-544-6664
Monday – Friday: 7:30 AM – 5:00 PM EST

A Member of
US Employee Benefits Services Group.

New London Public Schools partners with Liberty Mutual to help you save $782 or more a year on auto and home insurance.[1]

Enjoy the benefits of being part of a community.

You could **save up to $782 a year,** and you'll have access to all the advantages of being a Liberty Mutual customer:

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No premium increase due to an initial accident

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24-Hour Roadside Assistance[4]
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Liberty Mutual. INSURANCE



Contact me for a free quote.

Paul Martinez
914 Hartford Turnpike, Suite 103
Waterford, CT 06385
860-383-1520
Paul.Martinez@libertymutual.com
135535

[1] Average combined annual savings based on countrywide survey of new customers from 1/1/15 to 1/29/16 who reported their prior insurers' premiums when they switched to Liberty Mutual. Savings comparison does not apply in MA. [2] For qualifying customers only. Accident Forgiveness is subject to terms and conditions of Liberty Mutual's underwriting guidelines. Not available in CA and may vary by state. [3] Optional coverage in some states. Availability varies by state. Eligibility rules apply. [4] With the purchase of optional Towing & Labor coverage. Applies to mechanical breakdowns and disablements only. Towing related to accidents would be covered under your Collision or Other Than Collision coverage.

Coverage provided and underwritten by Liberty Mutual Insurance and its affiliates, 175 Berkeley Street, Boston MA 02116.
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Valid through June 22, 2018.



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Employees who take advantage of the ***Homestead Employer Affinity*** program are eligible for special discounts!

Whether ***purchasing, refinancing, or renovating*** a home the following program benefits can apply...

- No Processing Fees
- No Underwriting Fees
- No Application Fees

Contact Keith Turner For Details And A Free Credit Analysis!

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Homestead Funding's Appraiser will REDUCE THE APPRAISAL FEE	**SAVE *$75.00***
Homestead Funding's bank attorney will REDUCE THE SETTLEMENT FEE	**SAVE *$245.00***

Total Savings of $520.00!



KEITH TURNER
Mortgage Loan Representative
Office: 860-444-0650
kturner@homesteadfunding.com

HOMESTEAD FUNDING CORP.
Home Financing That Moves You

8 Union Street, New London, CT 06320
NMLS ID# 820813 • CT Loan Originator Lic# 820813
Company NMLS ID#3232

Offer must be submitted with initial mortgage application. Cannot be combined with any other offer. Employees are free to select their own service providers where applicable, these discounts are merely available should employees choose to use a participating service provider. Effective 8/27/18. Subject to change without notice. *

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New London CT Public Schools Employees



Exclusive employee offer

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AMPLIFIED

Discounts on all qualifying accounts. 33% based on 4 line account.

Great news. You work at New London CT Public Schools Employees

Get the hook-up with T-Mobile Amplified™—**exclusive savings of up to 33% off on 4 lines (with AutoPay) for you and your family and not available in stores**. Make the switch and score unlimited talk, text, data and premium features—all on America's Fastest 4G LTE Network.

Unlimited data while on our network. On all T-Mobile plans, during congestion, the small fraction of customers using >50GB/mo. may notice reduced speeds until next bill cycle due to data prioritization. Video streams on smartphone at 480p.

What sets us apart:

- **T-Mobile Tuesdays**—download the free app and get thanked every Tuesday with free stuff and awesome deals
- **One price, ALL IN**—say goodbye to bill shock and surprise fees because the price you see is the price you pay
- **Netflix on us**—now you can binge all your favorite shows at no extra charge when you sign up for 2+ qualifying lines

More unlimited for everyone

	T-Mobile ONE™	T-Mobile Amplified™
Talk, text and 4G LTE data on your smartphone	Unlimited	Unlimited
Mobile hotspot	Unlimited at 3G	Up to 20GB 4G LTE (then unlimited at 3G)
Video streaming	Unlimited 480p	Unlimited HD
Name ID/Scam ID	Add-on available with purchase	Included
FREE Gogo® in-flight Wi-Fi	1 hour per flight (unlimited flights)	Unlimited
International coverage in 210+ countries and destinations	2G data speeds 128kbps	2X faster data speeds up to 256kbps
Voicemail to text	Add-on available with purchase	Included
No-cost DIGITS® number with each line	Add-on available with purchase	Included

On all T-Mobile plans, during congestion, the small fraction of customers using >50GB/mo. may notice reduced speeds until next bill cycle due to data prioritization. HD must be enabled. Gogo-enabled flights to, from and within the U.S.

Added features. Bigger savings.

Number of lines	Amplified Market Value with AutoPay	Your Cost with AutoPay
1	$90	$70 *(22% off)*
2	$160	$120 *(25% off)*
3	$200	$140 *(30% off)*
4	$240	$160 *(33% off)*

Get T-Mobile Amplified today.

Call **855-570-9947** and use promo code **36026TMOFAV**

Or if you have any questions, contact me directly:

FAQs or Order on Line Visit: www.t-mobile.com/amplified

Joanne Pritts - joanne.pritts@t-mobile.com

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