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.

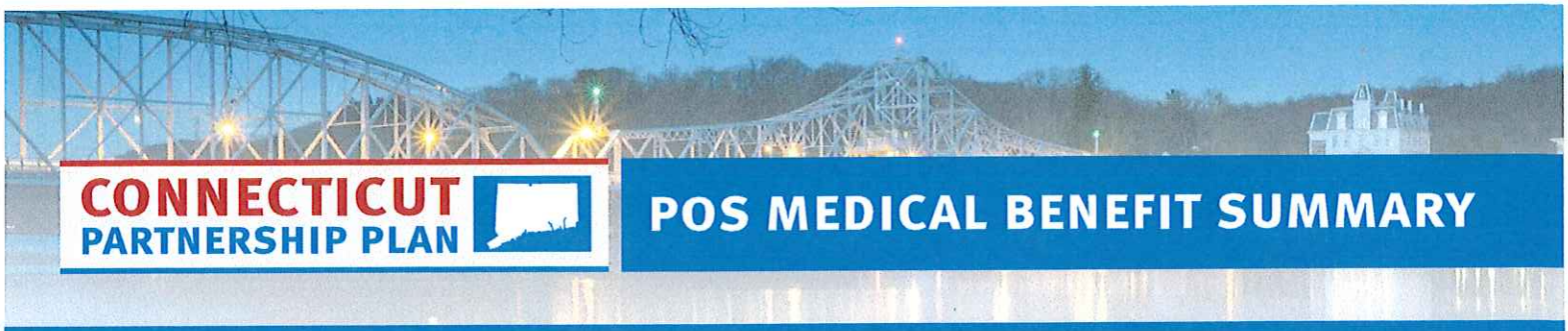
The CT Partnership Plan is the same POS plan currently offered to State of Connecticut employees. You get the same great healthcare benefits that state employees get, including $15 in-network office visits (average actual cost in CT: $150*), free preventive care, and $5 or $10 generic drug copays for 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

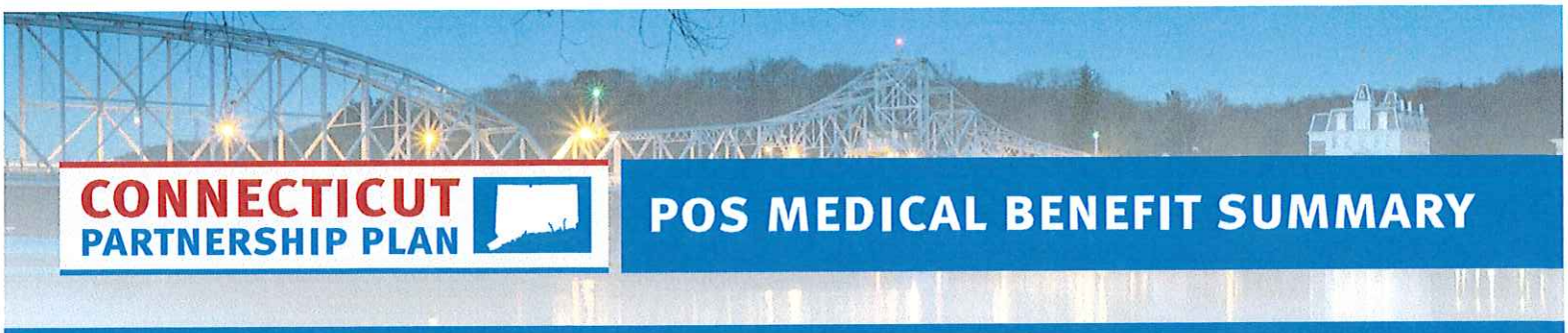
POS MEDICAL BENEFIT SUMMARY

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.

(continued on next page)



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.

Anthem

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

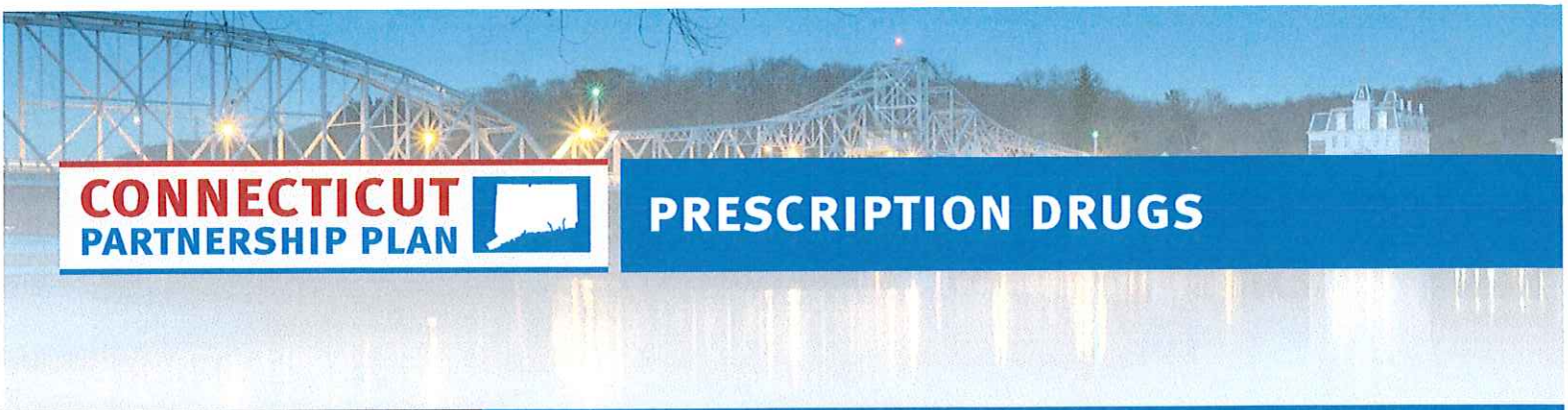
Customer service helps you get answers and much more

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.

59142CTMENABS Rev. 03/19



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).

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 2022 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	40-44: N/A 45+: 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

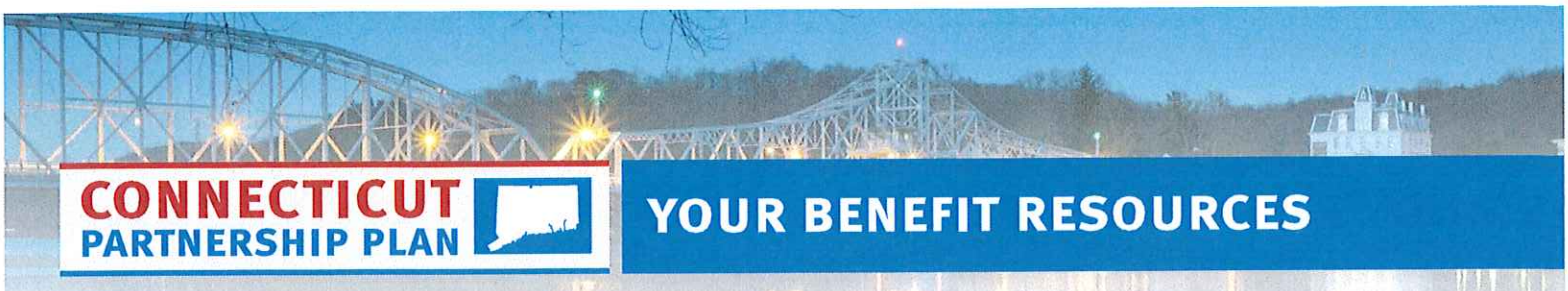
If you or any enrolled dependent becomes non-compliant in HEP, your premiums will be $100 per month higher and you will have an annual $350 per individual ($1,400 per family) in-network medical deductible.

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.



CONNECTICUT PARTNERSHIP PLAN

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.

Connecticut Partnership Plan
Add / Term / Change Form

Anthem Group Number:	
Cigna Branch Code:	
*For HR Use Only	

New Enrollee(s):	
Term Subscriber:	
Term Dependent(s):	
Change Information:	
*For HR Use Only	

EMPLOYER NAME:	
EMPLOYEE NAME: (Last, First)	
EMPLOYEE STREET ADDRESS:	
CITY, STATE & ZIP:	
EMPLOYEE PHONE NUMBER & EMAIL:	

*Note: Phone number is vitally important. Without a valid phone number, we are unable to contact members regarding clinical programs or HEP programs.

EFFECTIVE DATE:	

COVERAGE ELECTIONS:	Medical/RX	Dental	VISION
Employee			
Employee + 1			
Family			
Waiver			
COBRA			

	NAME Last, First	Date of Birth	Social Security Number	Gender	Add / Term
EMPLOYEE					Add / Term
DEPENDENT (Spouse)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term

MEDICARE INFORMATION
Member Name: _____
Medicare ID Number: _____
Part A Effective Date: _____
Part B Effective Date: _____

EMPLOYMENT INFORMATION:
- Employment Status: _____
(Example: FT, PT, Disabled, Retired)
- Number of Hours worked per week: _____
- Hire Date: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

By signing this CT Partnership Plan enrollment form, I agree, on behalf of myself and all enrolled dependents, to participate in the Health Enhancement Program (HEP). I understand that I will lose the financial incentives of the HEP program if I or any of my enrolled dependents fails to comply with the requirements of the HEP program.

Anthem

OFFICE of the STATE COMPTROLLER

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
Town of East Windsor
C1 - Custom PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	**In-Network Benefit**	**Out-of-Network Benefit**	**Frequency Period ****
Exam Copay	$15	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$0	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $40 Up to $65 Up to $75 Up to $100	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 Up to $360 Covered 100%	 Up to $345 Up to $345	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $175	Up to $126	12 months
** Your Frequency Period begins the day after your last visit (Date of service basis)			

Definitions:
Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 18 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults) all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription eyeglasses, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log in to **myCigna.com**, go to your Cigna Vision coverage page and select "View Details." Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to **myCigna.com**? Go to **Cigna.com** and click on the orange Find a Doctor tab at the top. Then select "Vision Directory", for routine eye exams and eyewear services, from the Other Directories listed below.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision

customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
- Go to **Cigna.com** and go to Forms, Vision Forms
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

ATTENTION: language assistance services, free of charge, are available to you. Call 1-877-478-7557 (TTY: 800-428-4833).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-478-7557 (TTY: 800-428-4833).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-478-7557（TTY：800-428-4833）

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-478-7557 (TTY: 800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-877-478-7557 (TTY: 800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Tumawag sa 1-877-478-7557 (TTY: 800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-478-7557 (телетайп: 800-428-4833).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-778-874-7557 [(رقم هاتف الصم والبكم: 800-428-4833).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-478-7557 (TTY: 800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-478-7557 (ATS: 800-428-4833).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1-877-478-7557 (TTY: 800-428-4833).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-478-7557 (TTY: 800-428-4833).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-478-7557（TTY: 800-428-4833）まで、お電話にてご連絡ください。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-478-7557 (TTY: 800-428-4833).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-478-7557 (TTY: 800-428-4833).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 800-428-4833) 1-877-478-7557 تماس بگیرید.

Cigna Dental Benefit Summary
Town of East Windsor - Full ABCD Plan
Plan Renewal Date: 07/01/2022

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	***In-Network:*** **State of Connecticut Network**		***Non-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	Unlimited		Unlimited	
Calendar Year Deductible Individual Family	$0		$0	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Oral Surgery: minor Repairs: Dentures Crowns: prefabricated stainless steel / resin	100% No Deductible	No Charge	100% No Deductible	No Charge
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: permanent cast and porcelain Bridges and Dentures Space Maintainers: non-orthodontic Oral Surgery: major	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 Lifetime Benefits Maximum: $600	60% No Deductible	40% No Deductible	60% No Deductible	40% No Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 85th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.			
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.			
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.			
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.			
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III, IV, and VIII services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.			

Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program*	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 14.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months 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.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months 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.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Anesthesia; Brush Biopsy;
- Prosthodontic: precision or semi-precision attachments;
- Denture Relines, Rebases and Adjustments; Repairs - Bridges, Crowns, and Inlays;
- Implants: implants or implant related services;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

CIGNA DENTAL VIRTUAL CARE

Helping customers access dental care without leaving home

The dentist will see you now.

Toothaches, chipped teeth and oral infections don't care what time of day it is. But neither do the **Cigna Dental Virtual Care**[1] dentists. If you need dental care and are unable to reach your regular provider, you now have the option to consult with a dentist through a video call. The best part? **Cigna Dental Virtual Care** is available **24 hours a day, seven days a week, 365 days a year!**

Convenient dental consults at home.

While we recommend that you contact your dentist first to see if they can provide virtual care, we recognize that this may not always be possible. That's why we've partnered with The TeleDentists, a virtual dental care company that's been serving customers since 2018. The TeleDentists connects you with a licensed dentist who, through a video call, can help address urgent dental situations like toothaches, infection, swelling, bleeding, and more. They can also prescribe medication[2] to be filled at your local pharmacy, if necessary.

The nature of this type of care delivery precludes dentists from performing more involved procedures, but if the dentist determines such care is needed, they can help guide next steps.

Cost and claim information.

Cigna Dental Virtual Care consults are processed as in-network claims on your plan, and have no co-pay or coinsurance costs. Although Cigna Dental Virtual Care consults do not apply to frequency limits you may have on your plan, they do apply to your plan's annual maximum, if applicable.

How to access Cigna Dental Virtual Care.

If your dentist is unable to assist with your urgent dental care need, simply log on to your **myCigna.com** account and follow the prompts to the virtual care portal.

- You **must** connect to the portal via your **myCigna.com** account in order to use the service without having to enter a payment method.
- Once you've entered the online portal, you will be prompted to create an account on "The TeleDentists" website, and provide basic health information.
- You will be prompted to download and install a video chat application, and then confirm whether you want to see a dentist now, or schedule an appointment for a later time.
- When you are ready to consult with a dentist, you'll enter a virtual waiting room where a dentist will connect with you in ten minutes or less.

Together, all the way.®

Cigna.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

937788 04/20

Frequently asked questions.

My dentist offers virtual visits and is in the Cigna network. Can I use them at no cost if I need urgent care?

Yes! We recommend calling your dentist first as many do provide virtual care.[3]

What if I already have an account with The TeleDentists? Can I use that and still have my costs waived?

In order to have your consult covered by your plan, you must link to The TeleDentists site from your myCigna.com account. This identifies you as a Cigna customer eligible for a consult. Once on the Cigna-branded landing page, you may sign in using your existing account information.

Can my enrolled dependents use this service and are there limitations on the age of patients?

Your enrolled dependents may also use the service. All ages can be evaluated by the dentists on The TeleDentists site, although those under the age of 18 will need to be "accompanied" by a parent or guardian.

Why do I have to create an account on The TeleDentist website? Is it secure?

- In order to provide care, The TeleDentists site needs some information about you, including basic health information, medications you take, allergies you have, etc. This will help the dentist make the most appropriate recommendations during your consult.
- The TeleDentists site meets all federal requirements for protecting personal health information under the Health Insurance Portability and Accountability Act (HIPAA).

Can The TeleDentist dentist prescribe medications if I need them?

Dentists can prescribe medications such as antibiotics and non-narcotic pain relievers. The dentist will send any required prescriptions to the pharmacy of your choice. There may be pharmacy costs associated with filling the prescription, depending on your medical or prescription plan.[4]

Do I have to use the video chat function to talk with a dentist? Can they just talk to me on the phone instead?

They are unable to provide consultations by telephone, because the dentist needs to be able to see you and any visual symptoms of the problem you're having. Video chat is the only way a consult can be performed. It's convenient because it allows you to show the dentist things like a broken tooth, inflammation or other problems you're experiencing.

If you have questions, log on to myCigna to chat with a representative or call 1-800-Cigna24. You can also call the number on the back of your ID card.

Cigna.

1. Availability of Cigna Dental Virtual Care services may vary by location and plan type and is subject to change.
2. Dentists are unable to prescribe opioid or narcotic medications, and are subject to all laws in your residence state regarding the prescribing of medication.
3. Virtual consultations with Cigna network dentists are subject to applicable frequency limits and annual plan maximums.
4. Prescription medications are not covered on Cigna Dental plans. For information on out-of-pocket costs for prescribed drugs, please refer to your medical or pharmacy plan documents.

All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents. The TeleDentists is an independent company and is not affiliated with Cigna. Providers are solely responsible for any treatment provided. Video chat may not be available in all areas. Services are separate from the Cigna dental plan provider networks.

CARE
MANAGEMENT
SOLUTIONS®

A DIVISION OF WELLSPARK

Health Enhancement Program (HEP)

Welcome to the State of Connecticut Health Enhancement Program

Care Management Solutions Inc. (CMSI), a division of WellSpark 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

CARE MANAGEMENT SOLUTIONS

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

HEP Requirements

2022 HEP REQUIREMENTS

MORE INFO: WWW.CTHEP.COM | (877) 687-1448

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 (Pap Smear)	N/A	N/A	Every 3 years (21+)	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	40-44: N/A 45+: Colonoscopy every 10 years, Annual FIT/FOBT to age 75 or Cologuard screening every 3 years	

* Dental cleanings are required for family members who are participating in a dental plan sponsored by your employer
** Or as recommended by your physician
‡ NEW: colorectal screening age requirements lowered to 45 years of age for calendar year 2022 as recommended by US Task Force on Preventive Services

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

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**

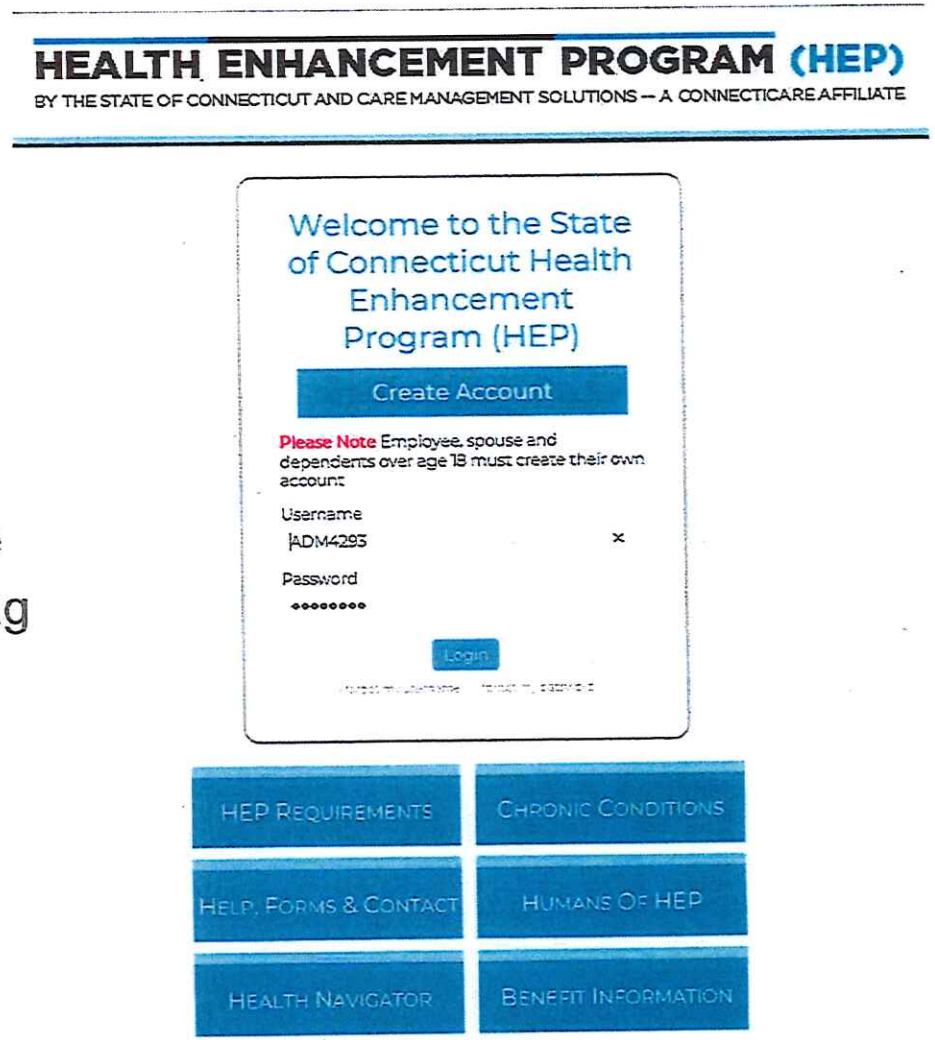
Benefits of HEP

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

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**

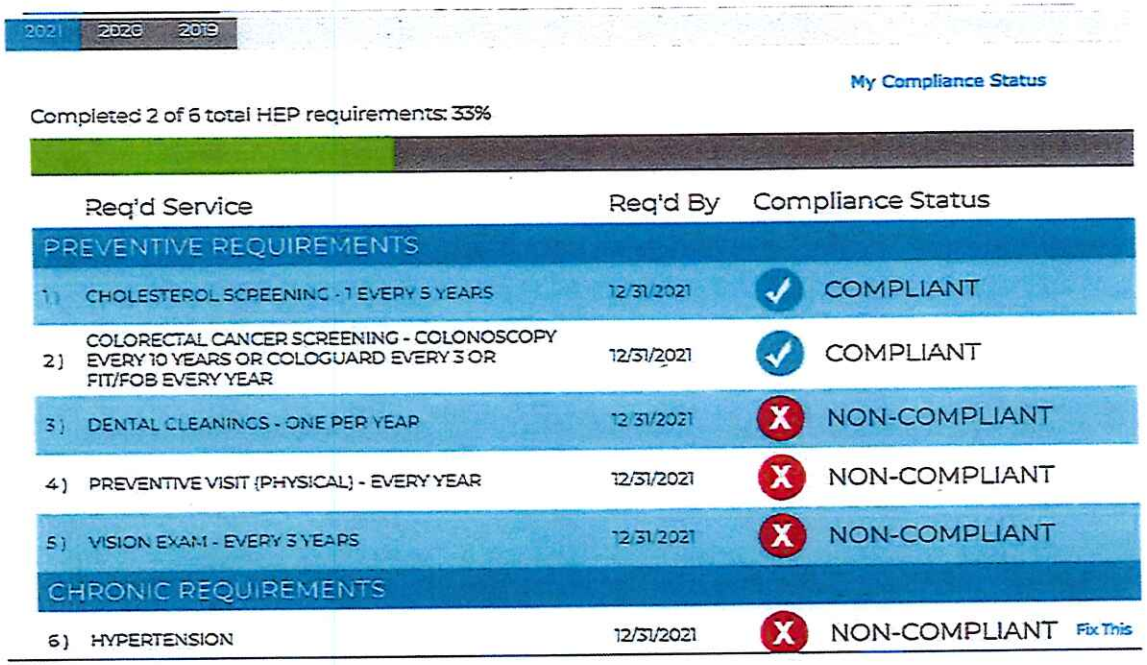


CARE MANAGEMENT SOLUTIONS

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

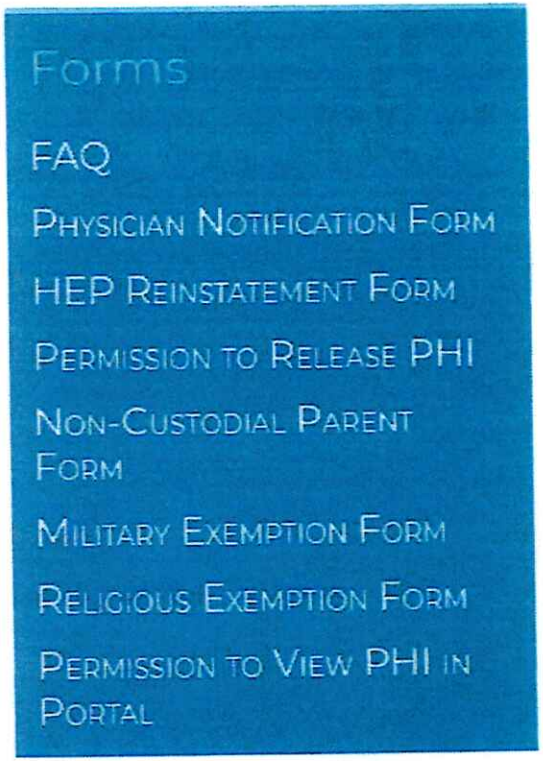


Help, Forms & Contacts

- 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



CARE MANAGEMENT SOLUTIONS

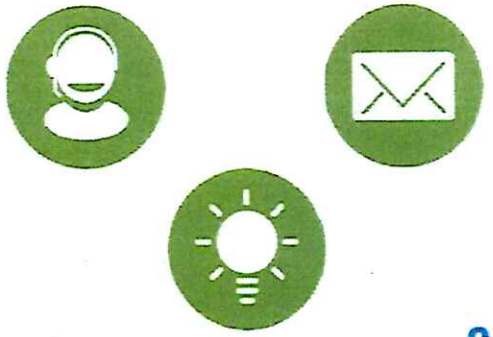
Questions or Concerns?

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



CARE MANAGEMENT SOLUTIONS

HEALTH ENHANCEMENT PROGRAM (HEP)

FAQ

Q: What is HEP?

A: HEP stands for "Health Enhancement Program." It encourages employees and their enrolled family members to take charge of their health and their health care by providing guidelines to follow for preventive and chronic care management. By signing up for and fulfilling all HEP requirements, you can save $100 per month in premiums ($1,200 per year) and become eligible for a waiver of an annual in-network deductible of $350 per member (up to a maximum of $1,400 per family).

Q: What are the requirements?

A: There are two parts to HEP: age/gender appropriate preventive requirements and chronic condition education requirements.

Preventive requirements:

2022 HEP REQUIREMENTS

MORE INFO: WWW.CTHEP.COM | (877) 687-1448

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 (Pap Smear)	N/A	N/A	Every 3 years (21+)	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	40-44: N/A 45+: Colonoscopy every 10 years, Annual FIT/FOBT to age 75 or Cologuard screening every 3 years	

* Dental cleanings are required for family members who are participating in a dental plan sponsored by your employer
** Or as recommended by your physician
‡ NEW: colorectal screening age requirements lowered to 45 years of age for calendar year 2022 as recommended by US Task Force on Preventive Services

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

Chronic condition education:

We provide support and education for participants with asthma, chronic obstructive pulmonary disorder (COPD), coronary artery disease (CAD), diabetes, heart failure, hypertension (high blood pressure), and hyperlipidemia (high cholesterol).

In order to meet the chronic education requirement, you have a few options. One option is to register on the portal at CTHEP.com and take a short survey, read a fact sheet, or watch a video on your specific condition. Another option is to call our care team at 1-877-687-1448.

If one of our dedicated nurse care managers calls you, you are required to have at least one conversation. If the nurse recommends that you participate in a support program, that decision is entirely up to you. It is not a requirement, but it is highly encouraged.

Q: When does the program start?
A: The program runs on a calendar year basis so each year on January 1st a new compliance year begins. Your requirements for the year are based on your age on that day. So, if you are 49 on January 1st, you are held to the requirements for a 49-year-old, even though you turn 50 in that calendar year.

Q: How does Care Management Solutions determine compliance?
A: Each year, CMSI loads your age appropriate preventive and chronic requirements to your HEP portal. As you obtain your required screenings, CMSI receives the claims data from your insurance carrier and uploads that data to your HEP portal. As the claims come in you will see your requirements marked as complete.

Q: How can I track my progress toward my requirements?
A: The best way is to register on **CTHEP.com**. Once you sign in, your home page will display your requirements based on your age and gender. You will also see any chronic condition(s) requirements that apply to you. You can see any dependents' information, too. If they are under age 18, you will be able to view specific requirements and progress. If they are over age 18, you will be able to review a summary to see how many requirements they have and how many have been completed.

Q: How do I know if my family members are compliant?
A: As mentioned above, if you register at **CTHEP.com**, you will be able to view specific requirements for dependents under age 18, for dependent over 18 you can view a summary. Dependents over age 18, can create their own secure login to see their individual status in the HEP program. If they would like you to have access to their individual requirements, they can sign a **personal health information** (PHI) release form that would grant you access.

Q: I am a new employee. I tried to register at CTHEP.com, but it doesn't recognize me.
A: It takes about 45 days for CMSI to receive your enrollment information. We recommend you wait until the middle of the month after your insurance goes into effect.

Q: I don't have access to a computer. How will I know if I am missing a requirement?
A: Everyone is notified by mail towards the end of the compliance year of any missing requirements. Dependents ages 18 and over will receive their own letters. You typically receive the first letter at the end of September and will continue to receive letters until we receive the claims showing the requirement(s) have been completed. You can also call the dedicated customer service team at CMSI at 1-877-687-1448 to discuss your compliance status.

Q: A service is required less frequently than every year – every 2, 3, 4, 5, 7, and even 10 years. Do I have that long to complete it?
A: Here's how those work: We will look back at claims the appropriate number of years to see if the requirement has been completed. Requirements are measured using the current compliance year. For example, for Compliance year 2020, if you are 45 years old, and a vision exam is required once every four years, on Dec. 31, 2020 we will look back to see if it was completed in either 2017, 2018, 2019, or 2020.

Q: I had a service that I needed before this insurance went into effect. Do I have to have it again?
A: No, you do not. Have your health care provider fill out a **provider notification form** (PNF) with the date the service was done and submit it to us (instructions are on the form). For example: you are a new employee (or a new Partnership group) who is 57 years old and had your colonoscopy seven years ago. That satisfies your requirement for a colonoscopy, but you must submit the PNF. You can access a PNF at any time at **CTHEP.com** under "FORMS" at the top of the home page.

Q: I had my physical in December of last year, and my doctor is telling me I cannot get one sooner than December of this year because of the insurance. What do I do? I am afraid if it gets cancelled due to weather I will be out of compliance.
A: You do NOT have to wait 365 days to schedule a preventive visit. Your insurance pays for one every calendar year, regardless of when in the calendar year you have it. If your provider has a question about this, they should contact your health insurance company.

Q: Are there any alternate options to a colonoscopy?
A: While a colonoscopy is the most accurate way to test for colon cancer, we know that it is not appropriate for everyone. If your doctor agrees, you can take an annual FIT or FOBT test, or you may take a COLOGUARD® test every 3 years.

Q: I can't do one of the requirements because I have dentures, had a hysterectomy, or had a mastectomy.
A: Have your doctor fill out a **PNF** indicating that you should be exempt from the service. Be sure they indicate it is a permanent exemption. When we receive the form, we'll remove the requirement for you.

Q: My doctor does not feel I need to have one of the requirements. Why do I have to do it?
A: If your doctor feels one of the requirements is not appropriate for you, they can fill out a **PNF**. This will be required every year unless it is a permanent exemption, as in the cases above.

Q: My physician checks my eyes during my annual physical wellness exam. Does that count toward the required vision exam?
A: Your in-office vision exam counts long as your doctor submits a claim to your insurance company with a procedure code indicating they completed an eye exam as part of your wellness exam. If your doctor does not bill or submit a claim for the vision exam, you will need to have him/her fill out a **PNF**.

Q: I went to the doctor. Why am I still showing non-compliant with a requirement?
A: We typically receive claims one to two weeks after they are processed by your insurance company. This can, however, vary with doctors' offices and their billing processes. If a couple of months has passed and the portal continues to reflect that you're noncompliant for a screening that you have already completed, then call CMSI so one of our representatives can assist you.

Q: I went to the doctor months ago. Why am I still showing as non-compliant for my preventive visit?
A: Going to a doctor for a problem, such as a sore throat or headaches, or a medicine check for a chronic condition does not satisfy the preventive requirement. The visit has to be specifically for a preventive exam, which is also referred to as a routine physical or well visit. For an adult, it typically includes lab work and screenings. For a child, it typically incudes immunizations. Preventive visits are intended to prevent illness or detect problems before you have symptoms.

Q: Why does it seem like I always have to submit a provider notification form (PNF)?
A: There are only a few situations that require you to submit a PNF:

1. Your dependents have other insurance, and that insurance is primary. In this case we will never receive a claim for preventive services, and you will always have to submit a form. You should bring the form at the time of service and ask the provider to complete it and send us a copy.
2. You had the service done before this insurance went into effect. Since we do not have past claims history, you will need to submit a PNF as proof you had the service.
3. You just had the service, but the compliance deadline is two months away. We recommend submitting a PNF rather than waiting for the claim to be processed and sent to us.

Q: If I'm showing one of the chronic conditions, how do I complete the requirement?
A: The chronic condition requirement is an educational requirement that is separate from a doctor's visit or bloodwork for that condition. The education can be done in one of these ways:

1. You create an account on CTHEP.com, then take a survey, read a factsheet, or watch a video. After you finish, simply hit the "submit" button.
2. If you prefer not to register, you can print a factsheet from the log-in page. You click the chronic conditions button, select the appropriate condition, print the fact sheet, fill it out and send it in to us.
3. You can call us at 877-687-1448 and a representative will help you take a quiz over the phone.

This is an annual requirement due by December 31 along with the preventive requirements. Please remember, too, that if one of our dedicated HEP nurses calls you, you must accept the call to be considered in compliance.

Q: I didn't get the mailing you sent. It went to my old address.
A: Make sure you notify your employer of your address change through your benefit officer, payroll officer, benefit administrator, or human resources department. They will send the change to us. This could take up to six weeks, depending on when we receive the notice.

Q. Why does my child have to be compliant? He/she will be turning 26 and coming off my health plan before the end of the year.
A: The state changed medical coverage requirements for dependents in 2019. Dependents who turn 26 during the year now stay on a parent's plan until the end of the calendar year instead of the first of the month following their 26th birthday.

Q: My spouse is a state retiree on Medicare and doesn't have to comply with HEP. If it's his policy, why do I have to meet the requirements?
A: If you are under 65 and a dependent of a retiree in the Medicare Advantage plan who based on retirement date (10/2/2011 and later) would otherwise be required to meet the requirements of HEP, the benefit provided to you includes all the components of HEP. You must be compliant with the requirements to continue to receive the financial benefits of the program.

Q: I am a new employee -- do I have to be compliant with HEP? Or, I just added a dependent -- do they have to be compliant with HEP?
A: HEP compliance is measured once you are in the program for a full year. For example, if the effective date of your insurance is Jan. 1, 2019, you must be compliant by Dec. 31, 2019. If the effective date of your insurance July 1, 2019, you must be compliant by Dec. 31, 2020.

Q: I am divorced and have no contact with my children who are in HEP.
A: You may download and print a **non-custodial parent form** from CTHEP.com. Find it under the "Forms" tab. Follow instructions on the form to complete and return it.

Q: My child is serving in the military. How can I get him/her to comply?
A: You may download and print a **military exemption form** from CTHEP.com. Find it under the "Forms" tab. Follow instructions on the form to complete and return it.

Q: Why can't I see my dependents' requirements? I pay for the insurance.
A: The Health Insurance Portability and Accountability Act (HIPAA) prevents us from disclosing this information without express consent from your dependent. Your dependent may give us permission by going to CTHEP.com and clicking on the "Help, Forms & Contact" box. Download and print the **release of personal health information (PHI) form** and follow the instructions.

Your dependent may also give consent for us to talk to you by registering at CTHEP.com. Then, he or she can sign in and click on the "Contact" information tab, scroll to the bottom, and fill out the HIPAA release section. Make sure to "save" before navigating away from the page.

Q: How do I get access to my adult dependents' requirements/status?
A: There are several ways:

- Have your dependent fill out a **PHI release form** (see above).
- Have your dependent register on the portal and give us permission (see above).
    - These two options allow you to call us and get information on your dependents.
- Have all your dependents 17 and over fill out the **PHI release form** and complete the cover sheet. This allows you access to their requirements thru the portal at CTHEP.com. This must be done annually.

Q: Why did I have extra money taken out of my paycheck?
A: When you are placed into a non-compliant status, your premium contribution increases by $100 a month. You should check CTHEP.com and get your missing requirement(s) done as quickly as possible. Once you've completed them, fill out the **reinstatement form** (find it on the portal) and send to CMSI. It can take one or two pay cycles before you see the change in your paycheck.

Q: If I'm out of compliance and being penalized, will I automatically be reinstated once I complete the requirement?
A: No, you won't be automatically reinstated. If you've completed a requirement, you must have a **reinstatement form** filled out by a health care provider and sent to us right away. That begins the reinstatement process. Claims for the service alone will not automatically reinstate you.

Q: I removed a non-compliant person from my insurance. Why wasn't I reinstated?
If you have removed a non-compliant person, please contact us right away so we can verify it and start the reinstatement process.

Q: I just completed my missing requirement and sent in my reinstatement form. When will I be reinstated?
A: You will be reinstated the first day of the month following receipt of a completed **reinstatement form**.

Q: Do I have to wait until open enrollment to be reinstated?
A: No, you don't have to wait. Please send us a **reinstatement form** with proof of your missing requirements right away. Once you (and any family members) are 100% compliant, we will send your name for reinstatement. That reinstatement is effective on the first day of the month following when you send in the reinstatement form. If you find that you're compliant but are being charged, please contact us immediately so we can assist you with the reinstatement process. It is your responsibility to know your compliance status in HEP.

Q: There are so many different forms – I don't know which one to use
A: There are a number of different forms that address very different circumstances –

- **Provider Notification Form** (PNF) – this formed is used to report a service you have had done and must be signed by your provider

- **Reinstatement Form** – Looks similar to a PNF, but this form is used if you are currently in a non-compliance status and are being penalized. This form must be signed by your provider if you are missing a preventive requirement. If you are missing the chronic condition education and you completed it on the portal, no provider signature is required

- **Non-Custodial Parent Form** – This form is to be used if you have a dependent child on your insurance plan and you do not have custody, so you cannot ensure his/her requirements are complete.

- **Military Exemption Form** – This is to be used if you have a dependent on your insurance plan that is actively deployed in the military.

- **Religious Exemption Form** - This form should be used to claim an exemption from the requirements of the Health Enhancement Program based upon your adherence to religious beliefs.

- **Permission to Release PHI** – This is the form a participant would fill out to release their Protected Heath Information (PHI). If you want to be able to speak to a customer service representative about your spouses or overage dependents specific requirements they need to complete this form and follow the instructions to return to us.

- **Permission to View PHI** - This is the form you must fill out and submit with a **Permission to Release PHI** (above) in order to view your spouse and overage dependents requirements on the portal. Everyone on your plan that is 17 or over must complete the required forms for this option. This must be done on an annual basis

All of these forms can also be found at **CTHEP.com** by clicking on the Help, Forms & Contact button, or by clicking on the forms tab.

CARE MANAGEMENT SOLUTIONS
A DIVISION OF WELLSPARK