CONNECTICUT PARTNERSHIP PLAN 2.0

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 **Expanded Access** 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 or visit osc.ct.gov/ctpartner.

*Source: Healthcare Bluebook: healthcarebluebook.com

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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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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.

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Using Your Benefits

When you need information about your benefits...

CareCompass.CT.gov is your one-stop shop for benefits and general information on your coverage. Click Partnership to view medical, dental, pharmacy and vision benefit information.

- Access your personalized benefits portal at **carecompass.quantum-health.com**, or by clicking Sign In on the Care Compass home page
- To view forms, visit **CareCompass.CT.gov/forms**, or click the Forms button at the bottom of the Care Compass home page.

When you need benefits support...

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

Earn incentives

If you select a Provider of Distinction for a qualifying procedure, you can earn a cash reward!

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

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

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

When you need to find the best provider or to find a location for a routine lab test...

Visit **osc.ct.gov/ctpartner** then scroll to **Find Providers**.

You pay nothing—$0 copay—for lab tests, if you visit a preferred Site of Service provider. To find a Site of Service provider, contact Anthem or **use the Find Care tool**.

When you're injured...

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

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

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

Help Managing and Reversing Diabetes

Get help managing Type 1 or Type 2 Diabetes with Virta Health. Members are connected and supported with access to a diabetes health coach and receive free testing supplies and tips to manage their A1c. In the diabetes reversal program, where members with Type 2 Diabetes can learn to eat their way to better health with personalized nutrition plans and support from medical providers, professional coaches, and digital health tools.

Help Preventing Diabetes

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

> To learn more about these programs, visit **CareCompass.CT.gov/diabetes**.

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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 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 (osc.ct.gov/ctpartner) and scroll down to Pharmacy under Benefit Summaries.)

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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 2023 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 (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	UPDATED 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.

To check your Health Enhancement Program compliance status, visit CareCompass.CT.gov, then sign in or register for your Quantum Health benefits portal. To view your status, click the My Health tab in your portal.

You can also download the MyQHealth app on the App Store or Google Play.

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.

Quantum Health is the administrator for the Health Enhancement Program (HEP) and gives you access to your personalized health benefits portal. The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. Login to your personal benefit portal at carecompass.quantum-health.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
- Send a secure message to a Care Coordinator for benefits assistance
- *Connect you to your medical, pharmacy, dental and other healthcare services covered in your plan- with just one login.*

Quantum Health: (833)740-3258, 8:30 a.m.-10 p.m. ET, Mon.-Fri.

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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

General benefit questions, Medical, and Health Enhancement Program (HEP)

Quantum Health
CareCompass.CT.gov **or login to your benefits portal from Care Compass**
833-740-3258

Prescription drug benefits

CVS Caremark
CareCompass.CT.gov/state/pharmacy **or login to your benefits portal from Care Compass**
1-800-318-2572

Dental and Vision Rider benefits

Cigna
CareCompass.CT.gov/state/pharmacy **or login to your benefits portal from Care Compass**
1-800-244-6224

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.