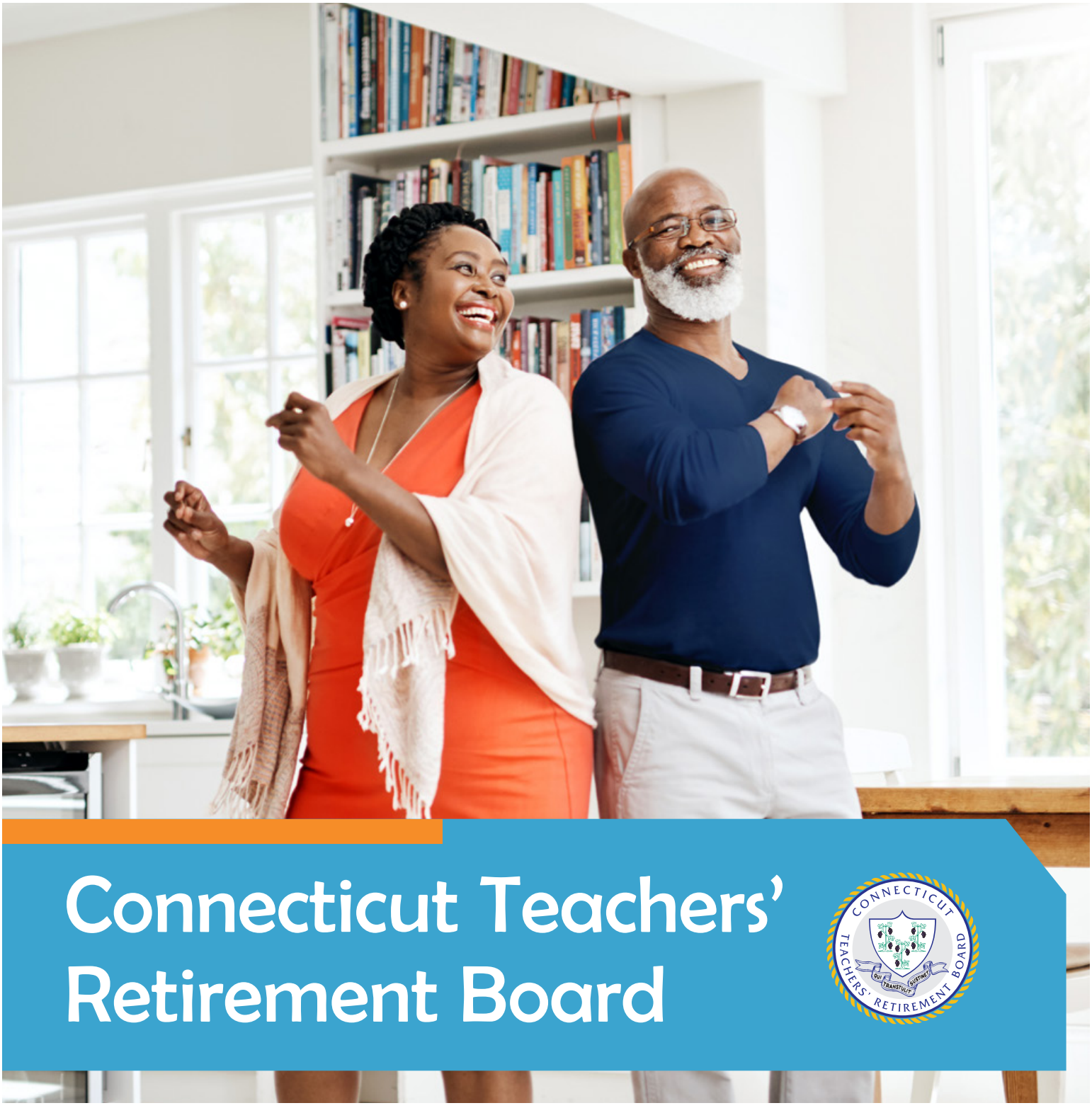
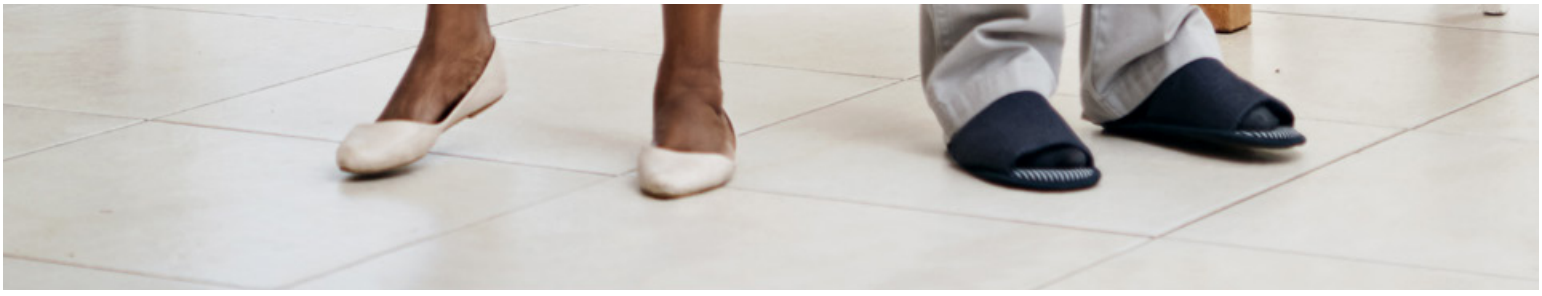


Connecticut Teachers' Retirement Board

2023 Enrollment Guide



Your Benefits

The Connecticut Teachers' Retirement Board (TRB) is proud to offer our retirees a generous, comprehensive health benefits package. This Enrollment Guide provides an overview of your benefits, which include:

- Medical
- Prescription drugs
- Dental *(does not apply to all)*
- Vision
- Hearing

Enclosed you will find the Open Enrollment meeting schedule.

2023 Benefit Plans

UnitedHealthcare® will continue to administer both medical plans as well as prescription drug coverage. Read this Open Enrollment Guide carefully to understand your medical plan options.

Medical	Definitions: • **Medicare Advantage Prescription Drug (MAPD) plan:** A type of Medicare Advantage plan that includes prescription drug coverage. This plan provides more coverage than Original Medicare, and you don't need to worry about a separate PDP (see below). • **Senior Supplement plan:** A medical plan that helps you pay for some or all of the costs Original Medicare does not cover, like copays and deductibles. • **Prescription drug plan (PDP):** A stand-alone prescription drug plan (Medicare Part D) that works with Original Medicare to cover prescription drugs
Prescription drugs	Prescription drug coverage is administered by UnitedHealthcare Medicare Rx. See page 12 for coverage details.
Vision	Routine eye exams are covered with both plans. Vision providers will submit claims for vision services to your medical plan.
Hearing	Routine hearing aid coverage is provided through the UnitedHealthcare Hearing network for both plans.

Moved recently?

Make sure the TRB has your most recent contact information on file. Contact the TRB with any changes as soon as they happen: 1-800-504-1102, TTY 711, 9:00 a.m.–3:00 p.m. ET.

Cost of Coverage

In addition to the costs you pay for Medicare Part B, you'll pay a monthly premium for your TRB coverage. The amount you pay depends on the medical plan in which you enroll—the Medicare Advantage plan or the Senior Supplement plan. If you enroll in one of the medical plans, you are enrolled **automatically** in the prescription drug, dental, vision, and hearing plans. Please note: Participants who enrolled into a TRB sponsored health plan and did not elect dental at that time or at a later date are not subject to the dental portion of the cost below. You do have the option to add dental during open enrollment by contacting TRB.

You'll pay the total amount shown at the bottom of this chart, based on the medical plan you select. The chart below shows the total premium for each plan.

	Medicare Advantage (PPO) Plan	Senior Supplement Plan
Medical and Prescription drug	$33.00	$276.00
Dental	$50.00	$50.00
Total	**$83.00**	**$326.00**

Cost of Medicare

If you are at least age 65 and you or your spouse worked and paid Medicare taxes for at least 10 years, you pay nothing for Medicare Part A. You'll pay a monthly premium for Medicare Part B, based on your income. The standard Part B premium is $170.10 for 2022 (pending Medicare 2023 rates).

Changing Your Coverage

You can change your coverage election each year during open enrollment, which takes place in the Fall each year. Coverage is effective the following January 1. If you would like to choose a different plan option, please call UnitedHealthcare toll-free at 1-866-794-3033, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

You may cancel your coverage at any time. However, if you do, **you cannot reenroll for two years without a qualifying event**. To cancel coverage, you must submit a cancellation form, available on the TRB website, or by contacting the TRB to have a copy mailed to you. You must submit the cancellation form 30 days before the month you want coverage to be cancelled. ***NOTE:*** *Retirees **do not** need to submit a cancellation form to continue coverage with TRB or to make a change.*

Eligibility

To be eligible for health care benefits, you must be receiving a benefit from the TRB. Additionally, you must be entitled to Medicare Part A and enrolled in Medicare Part B:

- **Medicare Part A:** Covers inpatient hospital care, skilled nursing care, home health care, hospice care, and inpatient drugs and therapies
- **Medicare Part B:** Covers doctors' services and outpatient care, preventive services, diagnostic tests and procedures, physical and occupational therapies, durable medical equipment, some outpatient prescription drugs, and some home health care

You must be enrolled in Medicare Part A and Part B to participate in the TRB Medicare Retirement Plans. Most people will qualify for Medicare Part A at no charge. If you (or your eligible spouse) have at least 40 Social Security wage quarters, have lived in the US at least 5 years and are age 65 (or older) you should qualify for Medicare Part A.

Medicare Part B requires a monthly premium that is income based. Higher income earners are assessed a surcharge referred to as IRMAA (Income Related Monthly Adjustment Amount) determined by the Social Security Administration. For more information, please visit **www.Medicare.gov**. IRMAA charges also apply for Medicare Part D premiums.

If you are receiving Social Security benefits, the monthly premium for Part B will be automatically deducted from your Social Security payment. If you are not receiving Social Security benefits, you will be billed quarterly for the Part B premium. This is a separate premium from the premium paid for TRB insurance.

If you fail to pay the Medicare premium, you will no longer be eligible to participate in any of the TRB Medicare Retirement Plans.

The Centers of Medicare and Medicaid (CMS) requires a physical street address, rather than a P.O. box, to approve coverage under the UnitedHealthcare Group Medicare Advantage (PPO) or UnitedHealthcare MedicareRx for Groups (PDP) prescription drug plan. UnitedHealthcare will continue to use your P.O. box address to send you important correspondence.

NOTE: *Please contact the TRB to make sure they have your current permanent physical address.*

Dependent Eligibility

If you are eligible for TRB benefits, certain dependents are also eligible, including:

- Your spouse
- Your disabled dependent child (if there is no spouse or surviving spouse / surviving ex-spouse)

Your spouse or eligible dependent must also be enrolled in Medicare Part A and B.

Surviving Spouse

A surviving spouse can enroll in TRB benefits if he or she:

- Has not remarried, and
- Would have been eligible for TRB benefits before your death.

Medical Benefits

You have two medical coverage options offered exclusively through TRB:

- **UnitedHealthcare® Group Medicare Advantage (PPO) plan:** The UnitedHealthcare Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract. You can see any provider (in- or out-of-network) at the same cost share, as long as they agree to see you and have not opted out or been excluded or precluded from the Medicare Program.
- **UnitedHealthcare® Senior Supplement plan:** Under this plan, UnitedHealthcare coverage supplements your Medicare coverage. Original Medicare (Parts A and B) will pay first. Then, UnitedHealthcare will pay for any remaining covered expenses, minus copays or cost shares, once you pay your annual deductible. You can see any provider in the United States who accepts Medicare or Medicare assignment.

Medical Plan Comparison

	UnitedHealthcare Medicare Advantage Plan	UnitedHealthcare Senior Supplement Plan
AMOUNTS ARE WHAT *YOU* PAY		
Medicare Part A		
Inpatient hospital	$200 copay per admission	$250 copay per admission
Medicare Part A		
Annual deductibles	$0	Part B: $233 (for 2022)
Annual out-of-pocket maximum	$2,000; excludes routine vision and hearing, foreign travel emergency	$2,233 ($2,000 plus the Part B deductible); excludes routine vision and foreign travel emergency copays or coinsurance amounts
Preventive care	$0 copay for Medicare-covered services	$0 copay for Medicare-covered services
Outpatient services: office visits	$10 copay for Medicare-covered services	$10 copay after deductible for Medicare-covered services
Outpatient: diagnostic tests (including radiation therapy, X-ray, PET, CT, SPECT, MRI scans)	$0 copay; may require prior authorization	$0 copay after deductible
Durable medical equipment	$10 copay; may require prior authorization	$0 copay after deductible

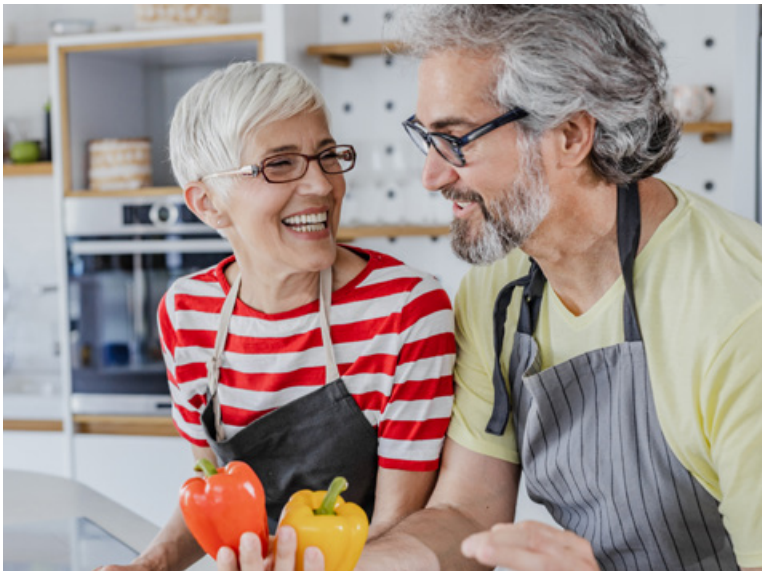
Overview of Medical Coverage

Covered Service	UnitedHealthcare Medicare Advantage Plan	UnitedHealthcare Senior Supplement Plan
AMOUNTS ARE WHAT *YOU* PAY		
Preventive care, including recommended immunizations and screenings	$0 copay for Medicare-covered services, including pneumonia, influenza, hepatitis B, or other Medicare-covered vaccines when you are at risk and meet Medicare Part B rules	$0 copay for Medicare-covered services, including pneumonia, influenza, hepatitis B, or other Medicare-covered vaccines when you are at risk and meet Medicare Part B rules
Outpatient diagnostic tests and therapeutic services and supplies	$0 copay for each Medicare-covered test*	$0 copay for each Medicare-covered test, after deductible
Diabetic supplies	$0 copay for diabetic supplies like blood glucose monitors, lancets and test strips*	$0 copay for diabetic supplies like blood glucose monitors, lancets and test strips
Continuous glucose monitors (Medicare approved, e.g. Dexcom G6 and Freestyle Libre)	$0 copay; must be purchased through Byram and/or Edgepark	$0 copay after deductible
Inpatient hospital care	$200 copay per admission; $0 copay for physician services received while an inpatient during a hospital stay*	$250 copay per admission; $0 copay for physician services received while an inpatient during a hospital stay
Inpatient mental health care	$200 copay per admission; $0 copay for physician services received while an inpatient during a hospital stay	$250 copay per admission; $0 copay for physician services received while an inpatient during a hospital stay
Skilled nursing facility	$0 copay for days 1–100*; you pay all costs after 100 days	$0 copay for days 1–20; $250 copay for days 21–100; you pay all costs after 100 days; requires 3 day minimum hospital stay
Home health agency care	$10 copay*	$0 copay
Physician office visits	$10 copay	$10 copay, after deductible
Chiropractic services	$10 copay*	$0 copay per visit, after deductible

** May require prior authorization*

Covered Service	UnitedHealthcare Medicare Advantage Plan	UnitedHealthcare Senior Supplement Plan
AMOUNTS ARE WHAT *YOU* PAY		
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	$10 copay*	$100 copay per visit, after deductible
Outpatient hospital services, nonsurgical	$10 copay*	$0 copay for outpatient hospital services $0 copay for outpatient tests
Ambulance services Provider approval required for nonemergency ambulance services	$100 copay*	$100 copay per ambulance, after deductible
Emergency care	$100 copay	$100 copay per visit, after deductible
Foreign travel	$100 copayment for worldwide coverage for emergency services. You do not pay this amount if admitted to the hospital within 72 hours for the same condition.	Medically necessary emergency care services beginning during the first six months of each trip outside the United States. First $250 each plan year.
Urgently needed services	$10 copay	$10 copay per visit, after deductible
Outpatient rehabilitation services	$10 copay*	$0 copay, after deductible
Routine vision services	Vision exam: $10 copay; maximum 1 per 12 months Eyewear: $0 copay, up to $240 maximum benefit; once every 24 months	Vision exam: $10 copay; maximum 1 per 12 months Eyewear: $0 copay, up to $240 maximum benefit; once every 24 months
Routine hearing services	Exam: $0 copay; Plan covers 100%; once every 12 months Hearing aids: $1,500 maximum benefit (in-network only); once every 3 years; includes digital hearing aids	Exam: $0 copay; Plan covers 100% once every 12 months Hearing aids: $5,000 maximum benefit (in-network only); once every 2 years; includes digital hearing aids
Outpatient substance abuse and mental health care, including partial hospitalization services	$10 copay for each Medicare-covered individual, group, partial hospitalization, and outpatient hospital facility visit	$10 copay for each Medicare-covered individual, group and outpatient hospital facility visit $0 copay for partial hospitalization

* *May require prior authorization*



Prescription Drugs

Your TRB prescription drug coverage is a Medicare Part D Prescription Drug plan with an employer group wrap administered by UnitedHealthcare in partnership with OptumRx. You have access to more covered prescription drugs than a traditional Medicare Part D Prescription Drug plan. The Prescription Drug plan is the same for Medicare Advantage Plan and the Senior Supplement Plan,

When you fill a covered prescription, you'll first pay a $200 deductible.
Once the deductible is met, you pay coinsurance:

- 5% for generic medications
- 20% for preferred brand name medications
- 30% for nonpreferred brand name and specialty medications

You continue to pay coinsurance until you meet the $3,500 maximum out-of-pocket (MOOP) per calendar year.

NOTE: *Certain prescription drugs, including clotting factors, drugs for dialysis, and antigens, are covered under your medical coverage. Contact UnitedHealthcare Customer Service for more information.*

If you are currently enrolled in another Medicare Prescription Drug plan or a Medicare Advantage plan that offers prescription drug coverage (MAPD) and you enroll in TRB benefits, your other coverage will be cancelled automatically.

Prescription Drug Formulary

The formulary is the list of prescription drugs covered by the plan. If a prescription is not on the formulary, you must pay the full cost. The formulary is available at **retiree.uhc.com/TRB** or **ct.gov/trb**.

From time to time, a drug may move to a different coverage tier (e.g., brand to nonpreferred brand). If a drug you are taking is moving to a higher tier, or if the change limits your ability to fill a prescription, OptumRx will notify you before the change.

TRB Rx Coverage and Medicare Part D

Your TRB prescription drug coverage is, on average, expected to pay out at least as much as standard Medicare prescription drug coverage. This means if you end TRB coverage and enroll in a new Medicare Part D plan, you will not incur a penalty, provided there is no lapse in coverage.

Step therapy

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

What is prior authorization?

Prior authorization (PA) is also known as precertification, prior notification, or prior approval. No matter what it is called, PA is basically a way to verify the medication is covered by your plan. PA also helps control costs for everyone.

A drug might require prior authorization if it is:

- A brand-name drug that has a generic equivalent
- More costly than other drugs within the same category/class
- Used for cosmetic reasons only

To help the prior authorization process go smoothly, it might be helpful to:

- Check the policy documents or Prescription Drug List (PDL) to see if you need prior authorization indicated on the PDL by the letters “PA.”
- Work with your doctor to submit a prior authorization
- Keep careful records of your prior authorization to know when it expires
- Begin the process of getting a new prior authorization at least one month in advance

To find out if a drug needs prior authorization, call the number on your member ID card or sign in to your health plan account

Preferred-brand insulin

If you take preferred-brand insulin, you’ll pay 20% of the cost of the drug, up to a $25 maximum copay (31-day supply, deductible does not apply).

Finding In-Network Retail Pharmacies

Your Medicare Part D prescription drug coverage includes thousands of brand-name and generic prescription drugs. Check your plan's drug list to see if your drugs are covered.

You can choose from thousands of national chain, regional, and independent local retail pharmacies. Call UnitedHealthcare at 1-866-794-3033, TTY 711, 8:00 a.m.–8:00 p.m. local time, Monday–Friday or visit **retiree.uhc.com/TRB** for more information.

Save on Maintenance Medications

If you prefer the convenience of mail order, you could save time and money by receiving your maintenance medications through OptumRx® Home Delivery. You'll get automatic refill reminders and access to licensed pharmacists if you have questions.

In addition to OptumRx Home Delivery, most retail pharmacies offer three-month supplies for some prescription drugs.

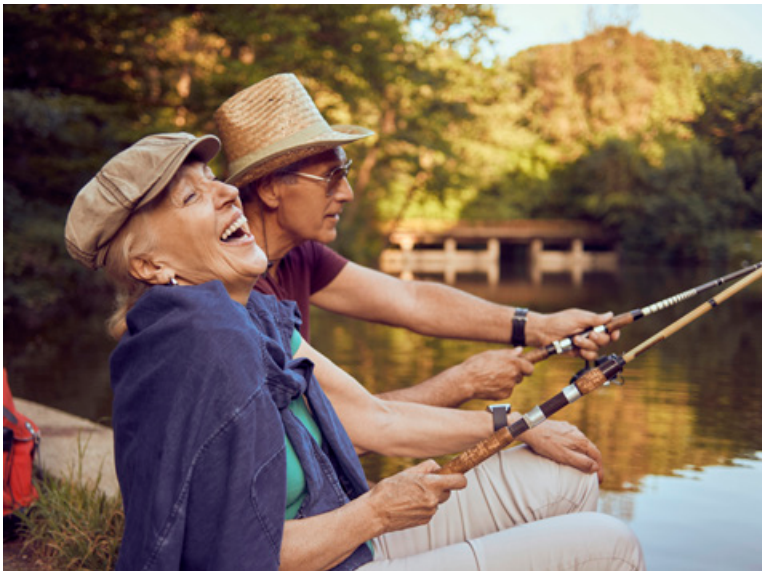
Long-Term Care Pharmacy

If you live in a long-term care facility, you'll pay the same amount that you would at a network pharmacy for your covered prescription drugs. Brand-name drugs must be dispensed in a 14-day supply or less; generic drugs must be dispensed in a 30-day supply or less.

Medicare Enrollment and Prescription Drug Coverage

While you may cancel your enrollment in TRB benefits at any time during the year, you can only enroll in a Medicare plan during certain times or under special circumstances.

If you leave the TRB plan and don't have or don't obtain other Medicare prescription drug coverage that is at least as good as Medicare's, you may pay a late enrollment penalty in addition to your premium for prescription drug coverage in the future.



Additional Medical Programs

Virtual Visits

If you are enrolled in either medical plan, you can see a doctor or a behavioral health specialist using your computer, tablet, or smartphone. With virtual visits, you're able to live video-chat—anytime, day or night. You will first need to register, and then schedule an appointment. On your tablet or smartphone, you can download the Amwell®, Doctor On Demand™, and Teladoc® apps.

There is no copay to use one of the apps, but a $10 copay may apply if you use a different telehealth service.

Virtual Doctor Visits

You can ask questions, get a diagnosis, or even get medication prescribed and have it sent to your pharmacy. All you need is a strong internet connection. Virtual doctor visits are good for minor health concerns like:

- Allergies, bronchitis, cold, or cough
- Fever, seasonal flu, sore throat
- Migraines or headaches, sinus problems, stomachache
- Bladder or urinary tract infections, rashes

Virtual Behavioral Health Visits

May be best for:

- Initial evaluation
- Medication management
- Addiction
- Depression
- Trauma and loss
- Stress or anxiety

UnitedHealthcare Fitness Program

Renew Active™ is the gold standard in Medicare fitness programs for body and mind, available at no additional cost. You'll receive a free gym membership with access to the largest Medicare fitness network of gyms and fitness locations. This includes access to many premium gyms, on-demand digital workout videos and live streaming classes, social activities, and access to an online Fitbit® community for Renew Active and an online brain health program from AARP®, Staying Sharp® (no Fitbit device is needed.)

Telephonic Nurse Support

Speak to a registered nurse 24/7 about your medical concerns at no additional cost to you.

UnitedHealthcare Hearing

Hear the moments that matter most with custom-programmed hearing aids. Get a hearing exam and access to brand-name and private-labeled hearing aids from any of our 7,000+ UnitedHealthcare Hearing providers nationwide.* Hearing aids purchased outside UnitedHealthcare Hearing's nationwide network are **NOT** covered.

**Please refer to your Evidence of Coverage for details on your benefit coverage.*

Dental Benefits

Dental health is about more than pearly whites and cavity prevention. Routine dental exams can reveal early warning signs of serious conditions like diabetes, osteoporosis, and some cancers.

That's why our dental plans offer routine exams.

Overview of Dental Coverage

Covered services include:

- Preventive and diagnostic services
- Basic restorative services
- Major restorative services

You can see in-network or out-of-network dentists. However, in-network dentists may save you money, because they participate in our Cigna DPPO network.

If you go out-of-network for care, you may have to pay the full cost at the time of service and then submit a claim form for reimbursement. Also, Cigna's reimbursement for out-of-network care is based on the maximum reasonable charge (MRC). The MRC is determined by Cigna Dental and is based on the range of fees charged by providers in your area with comparable training and experience for the same or similar service. You may be balance billed by your dentist for any amount above the MRC. When you receive in-network care, MRC charges **do not** apply.

What you pay for covered dental care expenses depends on whether you've met your annual deductible and if you're using a network dentist.

The dental plan covers routine exams in-network at 100% after deductible!

Here's what you'll pay for covered services:

	In-Network	Out-of-Network*
Network	Total Cigna DPPO network	N/A
Reimbursement levels	Based on contracted fees	Maximum reimbursable charge
Calendar-year benefits maximum	$2,500 per person	
Calendar-year deductible	$50 per person	
Benefit Highlights**		
Class I: Diagnostic and preventive Oral evaluations, routine cleanings, X-rays, fluoride application, sealants, space maintainers, emergency care	Plan pays 100%, after deductible	
Class II: Basic restorative Fillings, endodontics, periodontics, oral surgery, anesthesia	You pay 20%, after deductible	
Class III: Major restorative Repairs to bridges, crowns, inlays, dentures; denture relines, rebases, and adjustments; inlays and onlays; prosthesis over implant; crowns; bridges and dentures	You pay 50%, after deductible	

* *Reimbursement is based on the maximum reasonable charge (MRC) as determined by Cigna Dental. You may be balance billed by your dentist for any amount above the MRC.*

** *Benefit limitations may apply.*

The calendar-year dental plan benefit maximum is $2,500 per person.

Oral Health Integration Program

Cigna Dental Oral Health Integration Program offers enhanced dental coverage for participants diagnosed with diabetes, heart disease, stroke, chronic kidney disease, or for individuals who have had head and neck cancer radiation, an organ transplant, or who are pregnant.

If you qualify, you'll be reimbursed for the cost of certain dental procedures as well as guidance on behavioral issues related to oral health and discounts on prescription and nonprescription dental products.

Reimbursements are **not** subject to the annual deductible but **will** apply to the annual benefits maximum. For more information, visit **mycigna.com** or call 1-800-CIGNA24.

Finding In-Network Providers

To find an in-network dental provider, visit **cigna.com** and select **Find a Doctor, Dentist or Facility.**

Key Terms

Benefit maximums. Some health care services have a benefit maximum. This is the most your health plan—medical, prescription drug, dental, vision, and/or hearing—will pay in a given calendar year, or lifetime, toward certain covered expenses.

Brand-name drug. FDA-approved prescription drugs marketed under a specific brand name by the manufacturer. The FDA is the U.S. Food and Drug Administration.

Coinsurance. The percentage of the cost you pay when you receive certain eligible health care services. Generally, you start paying coinsurance after you meet your annual deductible (see "deductible" below).

Copay. The flat dollar amount you pay when you receive certain covered health care services.

Deductible. The amount you pay for covered services each plan year before the plan pays benefits. Once you've met the deductible, you share the cost of covered services with the plan through coinsurance or copays.

Formulary. A comprehensive list of prescription drugs that are covered by a prescription drug plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost effective. Formularies are updated periodically.

Generic drug. The FDA-approved therapeutic equivalent to a brand-name prescription drug containing the same active ingredients and costing less than the brand-name drug.

In-network. Providers or facilities that contract with a health plan to provide services at pre-negotiated fees. You usually pay less when using an in-network provider.

Maximum reasonable charge (MRC). The average fee charged by a particular type of health care practitioner within a geographic area. MRC is often used by medical plans as the most they will pay for a specific test or procedure. If the fees are higher than the approved amount and care is received from a non-network provider, the individual receiving the service is responsible for paying the difference.

Open enrollment. The time when you can change your health benefit elections for the following calendar year.

Out-of-network. Providers or facilities that are not in your health plan's provider network. For the medical plans, this is any non-Medicare provider.

Out-of-pocket costs. The amount you pay—including premiums, copays, and deductibles—for your health care.

Premium. The amount you must pay toward the cost of having health care.

Prescription drug tiers. The tier level of a drug determines how much covered medications cost. Generally, the higher the tier number, the more the drug will cost. Drugs can change tiers—or be removed completely from a formulary—during the year; review your plan's formulary regularly for the most up-to-date information.

Spouse / disabled dependent. A family member who meets the eligibility criteria on page 5 for plan enrollment.

Statements of Understanding

By enrolling in this plan, I agree to the following:

✔ **For members of the UnitedHealthcare® Group Medicare Advantage (PPO) plan only. This is a Medicare Advantage plan contracted with the federal government. This is not a Medicare Supplement plan.**

I need to keep my Medicare Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party. To be eligible for this plan, I must live in the plan's service area and be a United States citizen or be lawfully present in the U.S.

✔ **For members of the UnitedHealthcare® MedicareRx for Groups (PDP) only. This is a Medicare Prescription Drug plan and has a contract with the federal government.**

This prescription drug coverage is in addition to my coverage under the Senior Supplement medical plan. I need to keep my Medicare Part A and Part B, and I must continue to pay my Medicare Part B premium if I have one, and if not paid for by Medicaid or a third party. To be eligible for this plan, I must live in the plan's service area and be a United States citizen or be lawfully present in the U.S.

✔ **The service area includes the 50 United States, the District of Columbia and all U.S. territories.**

I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under these plans, when I am outside of the U.S. I am covered for emergency or urgently needed care. I understand that I must use network pharmacies except in an emergency when I cannot use the plan's network pharmacies.

✔ **I can only have one Medicare Advantage plan or Prescription Drug plan at a time.**

- Enrolling in one of these plans will automatically disenroll me from any other Medicare health plan or Medicare Part D Prescription Drug plan.
- If I enroll in a different Medicare Advantage plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
- If I disenroll from the Medicare Advantage plan, I will be automatically transferred to Original Medicare.
- Enrollment in these plans is for the entire plan year. I may leave these plans only at certain times of the year or under special conditions.

✔ **My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.**

Medicare may also release my information for research and other purposes that follow all applicable Federal statutes and regulations.

✔ **For members of the Group Medicare Advantage plan.**

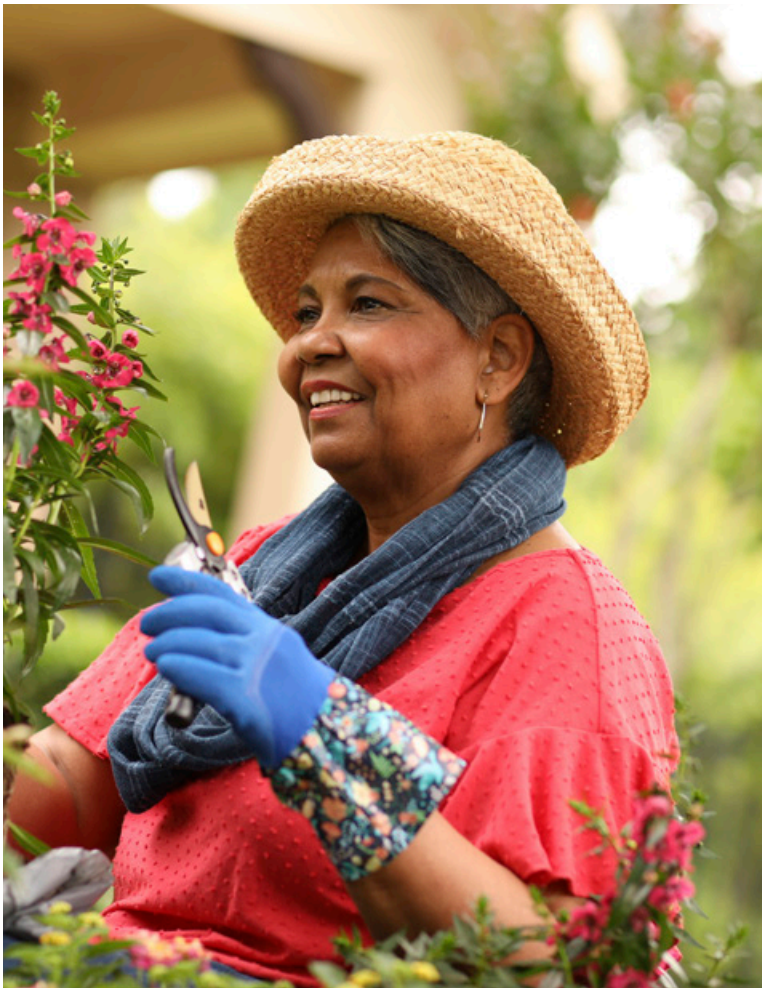
I understand that when my coverage begins, I must get all of my medical and prescription drug benefits from the plan. Benefits and services provided by the plan and contained in the Evidence of Coverage (EOC) document will be covered. Neither Medicare nor the plan will pay for benefits or services that are not covered.

✔ **For members of the Group Medicare Part D Prescription Drug plan.**

I understand that when my coverage begins, I must get all of my prescription drug benefits from the plan. Benefits and services provided by the plan and contained in the Evidence of Coverage (EOC) document will be covered. Neither Medicare nor the plan will pay for benefits or services that are not covered.

Notes

Notes



Contact Information

Benefit	Contact	Phone	Website
UnitedHealthcare plans (Medicare Advantage, Senior Supplement, and Prescription Drug)	UnitedHealthcare	1-866-794-3033, TTY 711, 8:00 a.m.–8:00 p.m. local time, Monday–Friday	retiree.uhc.com/TRB
Dental	Cigna Dental	1-800-244-6224 24 hours a day, 7 days a week	cigna.com or mycigna.com

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