CONNECTICUT TEACHERS' RETIREMENT BOARD

2021 ENROLLMENT GUIDE

What's Inside

Your Benefits

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

- Medical
- Prescription drugs
- Dental
- Vision
- Hearing

You have a choice between two types of medical plans. When you choose a medical plan, you also receive coverage for vision, hearing and dental. Consider your medical plan options carefully, and select the one that works best for you and your family.

Watch your mail for ID cards. If you're enrolled in a TRB medical plan, you'll be sent a new medical ID card effective January 1, 2021. If you're in the Anthem Medicare Supplement Plan, **your member ID number will change.**

2021 Benefit Plans

Medical	The Anthem Medicare Advantage Plan is the base plan for TRB. The TRB Medicare Supplement Plan is administered by Anthem. Under this plan, Medicare will pay the initial cost of covered services, then Anthem will pay. You are still responsible for the Part B deductible of $203 (in 2021). Then, you'll have copays for certain covered services such as a $250-per-visit copay for hospitalization.
Prescription Drugs	Prescription drug coverage will still be provided through Express Scripts. See page 16 for coverage details.
Vision	Submit claims for vision services to your medical provider. See page 22 for coverage details.
Hearing	Submit claims for hearing services to your medical provider. See page 23 for coverage details.

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: 800.504.1102.

You cannot contribute to your HSA once you enroll in Medicare. However, you can continue using the money in your HSA for qualified medical expenses. See irs.gov/publications/p969 for a complete list.

Enrolling in Coverage

Eligibility

To be eligible for benefits, you must be receiving a retirement benefit or disability allowance from the TRB. Additionally, you must be enrolled in Medicare Part A **and** 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.

ENROLLING IN MEDICARE

You typically become eligible for Medicare when you turn age 65. If you are younger than age 65, you may become eligible for Medicare if you are entitled to Social Security disability benefits or you are diagnosed with ALS (amyotrophic lateral sclerosis—also known as Lou Gehrig's disease) or end-stage renal disease.

If you are enrolling in Medicare because you are turning age 65, your initial eligibility for Medicare starts three months before your 65th birthday.

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 $148.50 (in 2021).

The effective date of your Medicare coverage is the first of the month of your 65th birthday. If you were born on the first of the month, your effective date is the first of the previous month.

NOTE: If you are receiving Social Security benefits before turning age 65, you are enrolled automatically in Medicare Parts A and B—you will not need to enroll during your initial eligibility period.

Contact the Social Security Administration with questions: **ssa.gov** or **800.772.1213**.

If you **are** receiving Social Security benefits, your Medicare Part B premium will be deducted from your Social Security benefits. If you **are not** receiving Social Security benefits, you'll be billed quarterly for your Part B premium. You must pay the Part B premium to be eligible for TRB benefits. The Part B premium is not included in TRB premiums and must be paid separately. For more information, visit **medicare.gov**.

If you or your spouse are actively employed and covered under a group health plan, you may be able to delay enrollment in Medicare Part B. Contact the Social Security Administration for more information on delaying Medicare enrollment without penalty: **ssa.gov** or **800.772.1213**.

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).

CONTINUING EMPLOYER COVERAGE

You and your spouse (or your unmarried surviving spouse) are eligible for a TRB subsidy if you:

- Retire,
- Are not eligible for Medicare, AND
- Continue your school district-sponsored health insurance.

Surviving Spouse

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

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

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 Anthem Medicare Advantage Plan or the Anthem Medicare Supplement Plan. If you enroll in one of the medical plans, you are enrolled automatically in the prescription drug, dental, vision and hearing plans.

You'll pay the total amount shown at the bottom of this chart, based on the medical plan you select. The chart shows how the total premium for all plans is divided among each of the coverages.

	Anthem Medicare Advantage Plan	Anthem Medicare Supplement Plan
Medical	$18	$121
Prescription drug	$46	$46
Vision	$8	$8
Dental	$53	$53
Total	**$125**	**$228**

FINANCIAL ASSISTANCE PROGRAMS

You may be eligible for financial assistance programs to help pay the cost of your coverage.

- **Low Income Subsidy Program.** If your income is limited, you may qualify for a government program that helps you pay for Medicare Part D prescription drug coverage. Find more information on **cms.gov**.
- **Medicare Savings Program.** The State of Connecticut offers financial assistance to eligible Medicare enrollees, including help paying Medicare Part B premiums, deductibles and coinsurance. Visit **bit.ly/ctmedicareprogram** to see if you qualify.

How to Enroll

The TRB requires that you must submit your application by the 25th of the month that's two months before you turn age 65. For example, if you would like your benefit to start June 1, you must submit your application to the TRB by April 25. REMINDER: To enroll in TRB benefits, you **must** also enroll in Medicare Parts A and B.

To enroll, submit the following documentation:

- **Application.** Visit **portal.ct.gov/TRB/Content/Health-Insurance/Health-Insurance-Menu/Forms** to download the application, or contact the TRB and have a copy mailed to you.
- **Proof of participation in Medicare Part A and Part B.** This can be a copy of your Medicare card or a letter from Social Security providing your Medicare ID number and the effective dates for Medicare Part A and Part B.
- **If you plan to cover your spouse.** A copy of your marriage certificate or marriage license.
- **If you plan to cover a disabled dependent.** A copy of your most recent federal income tax return showing you are claiming a disabled dependent as a tax dependent.

CHANGING YOUR COVERAGE

You can change your coverage election each year during Open Enrollment, which takes place during the Medicare open enrollment election period. Coverage is effective the following January 1.

You may cancel your coverage any time. However, if you do, you **cannot reenroll for two years. To cancel coverage, you must submit a cancellation form, available at portal.ct.gov/TRB/Content/Health-Insurance/Health-Insurance-Menu/Forms** or by contacting the TRB to have a copy mailed to you. You must submit the cancellation form by the 25th of the month before the month you want coverage to be cancelled.

Medical

New for 2021!
Acupuncture will be a covered benefit under both medical plans.

You have two medical coverage options:

- **Anthem Medicare Advantage Plan.** Under this plan, Anthem becomes the primary payer of your covered medical expenses. You can see any provider in the United States who accepts Medicare or Medicare assignment.
- **Anthem Medicare Supplement Plan.** Under this plan, Anthem coverage supplements your Medicare coverage. Original Medicare (Parts A and B) will pay first. Then, Anthem will pay for any remaining covered expenses once you pay the annual deductible. You can see any provider in the United States who accepts Medicare or Medicare assignment.

Medical Plan Comparison

	Anthem Medicare Advantage Plan	Anthem Medicare Supplement Plan
AMOUNTS ARE WHAT *YOU* PAY		
Medicare Part A		
Inpatient hospital	$200 copay/admission	$250 copay/admission
Medicare Part B		
Annual deductibles	$0	Part B: $203 (for 2021)*
Annual out-of-pocket maximum	$2,000; excludes routine vision and hearing, foreign travel emergency, or urgent care copays or coinsurance	$2,000 plus the Part B deductible; excludes routine vision and foreign travel emergency copays or coinsurance amounts
Preventive care	Plan pays 100% for Medicare-covered services	Plan pays 100% for Medicare-covered services
Outpatient services: office visits	$10 copay for Medicare-covered services	$10 copay after deductible for Medicare-covered services
Outpatient services: diagnostic tests (including radiation therapy, X-ray PET, CT, SPECT, MRI scans) and therapeutic services, diabetic and durable medical equipment and related supplies	$10 copay Prior authorization may be required	$0 copay after deductible

* Medicare Part B deductible subject to change.

Overview of Medical Coverage

Covered Service	Anthem Medicare Advantage Plan	Anthem Medicare Supplement Plan
AMOUNTS ARE WHAT *YOU* PAY		
Annual deductible	None	Part B: $203 (in 2021), subject to change
Annual out-of-pocket maximum	$2,000; excludes routine vision and hearing, foreign travel emergency, or urgent care copays or coinsurance	$2,000 plus the Part B deductible; excludes routine vision and foreign travel emergency copays or coinsurance amounts
Preventive care, including recommended immunizations and screenings	$0 copay	Covered if Medicare approves and pays for the services $0 copay for 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	$10 copay for each Medicare-covered test*	$0 copay for each Medicare-covered test, after deductible
Diabetes self-management training, diabetic services, and supplies*	$10 copay for a 30-day supply of blood glucose test strips, lancets, lancet devices, and glucose control solutions $10 copay for blood glucose monitor and therapeutic shoes/inserts $0 copay for diabetes self-management training	$10 copay for an office visit or other medical service, after deductible
Inpatient hospital care	$200 copay/admission; $0 copay for physician services received while an inpatient during a hospital stay*	$250 copay/admission; $0 copay for physician services received while an inpatient during a hospital stay
Inpatient mental health care	$200 copay/admission; $0 copay for physician services received while an inpatient during a hospital stay	$250 copay/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 the applicable cost-share amount after 100 days*	$0 copay for days 1–20; $250 copay for days 21–100; you pay all costs after 100 days
Home health agency care	$10 copay*	$0 copay
Hospice care	$10 copay for one-time-only hospice consultation	$250 copay
Physician services, including doctor's office visits	$10 copay	$10 copay for an office visit or other medical service, after deductible

*May require prior authorization

Covered Service	Anthem Medicare Advantage Plan	Anthem Medicare Supplement Plan
AMOUNTS ARE WHAT *YOU* PAY		
Chiropractic services	$10 copay*	$0 copay/visit, after deductible
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	$0 copay, after deductible
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*	$10 copay	$100 copay/visit, after deductible
Outpatient hospital services, nonsurgical*	$10 copay	$10 copay/visit
Ambulance services Provider approval required for nonemergency ambulance services*	$100 copay	$100 copay/ambulance, after deductible
Emergency care	$100 copay	$100 copay/visit, after deductible
Urgently needed services	$10 copay	$10 copay/visit, after deductible
Outpatient rehabilitation services*	$10 copay	$0 copay for an office visit or other medical service, after deductible
Durable medical equipment and related supplies	$10 copay*	$0 copay, after deductible
Routine vision services	Vision exam: $10 copay; max. one per year Eyewear: $0 copay, up to $240 max. benefit; once every 24 months	Vision exam: $0 copay; max. one per year Eyewear: $0 copay, up to $240 max. benefit; once every 24 months
Routine hearing services	Exam: Plan covers 100%; $70 maximum benefit once every 12 months $1,500 maximum benefit for hearing aids, once every 36 months	Exam: Plan covers 100%; once every 12 months Hearing aid fitting: Plan covers 100%; once per covered hearing aid Hearing aids: Plan covers 100%, one aid per ear; once every 24 months; upgrades, like deluxe or bluetooth devices, are not covered

* May require prior authorization

Coverage for International Expenses

Prescription drugs and lab charges are **not** covered out of the country.

LiveHealth Online

If you enroll in the Anthem Medicare Advantage Plan, you have access to LiveHealth Online®. LiveHealth Online offers 24/7 video-chat access to U.S.-based, board-certified doctors, on your smartphone, tablet or computer.

Use LiveHealth Online when you have a minor, nonemergency medical issue that otherwise might require a visit to your regular doctor or an urgent care center—like an ear infection, sore throat or a minor injury. Plus, the doctor can send prescriptions to your pharmacy of choice, if applicable.

For help with emotional issues, like stress or depression, make an appointment to talk to a licensed LiveHealth Online therapist or psychologist. In most cases, you can see a therapist or psychologist in four days or less.

You'll pay **nothing** for your LiveHealth Online visit—the Plan pays the entire cost! To learn more, visit **livehealthonline.com** or download the mobile app. When you sign up, make sure you have your health insurance card ready—you'll need it to answer some questions.

NOTE: Always call 911 in case of emergency. Only use LiveHealth Online for nonemergency medical situations.

SilverSneakers

If you enroll for benefits coverage, you have access to the SilverSneakers® fitness program from Tivity Health, Inc., at no additional cost. With SilverSneakers, you can join a local gym or take part in a fitness class designed specifically for seniors, including access to:

- More than 14,000 fitness locations throughout the country
- Support from trained instructors and group classes for all fitness levels and abilities
- On-demand workout videos led by a certified instructor on strength training, cardio fitness, yoga and stability
- SilverSneakers FLEX®, which allows you to participate in fitness classes right in your neighborhood, from a walking club to an aerobic dance class at your local recreation center.

- SilverSneakers GO mobile app—available from the App Store (iOS) or Google Play (Android). The app helps you find the nearest SilverSneakers location, access workout programs, set reminders, view your member ID number and more!

To get started, locate a participating facility, and find your SilverSneakers ID number at **silversneakers.com**. Then, visit your preferred location with your SilverSneakers ID number—you can visit more than one! Sign up with the person at the front desk.

For questions about SilverSneakers, call **888.423.4632** (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET.

Nurse HelpLine

You have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call, you can speak confidentially to a registered nurse who will help answer your health-related questions. The call is toll-free, and the service is available anytime, including weekends and holidays. Call the Nurse HelpLine: **800.700.9184** (TTY: 711).

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 Drugs

Your TRB prescription drug coverage is a Medicare Part D Prescription Drug Plan with an employer group wrap, administered by Express Scripts Medicare. This means that you pay less when you need to fill a prescription. You also have access to more covered prescription drugs than a traditional Medicare Part D Prescription Drug Plan.

You're protected from the high cost of prescription drugs by the Maximum Out-of-Pocket (MOOP) cost and the True Out-of-Pocket (TrOOP) cost.

The MOOP cost is the most you will pay for prescription drugs—Part D and non-Part D prescriptions—in a calendar year. It includes your deductible and any coinsurance. **For 2021, the MOOP cost is $3,500.**

The TrOOP cost includes:

- Amounts you paid out of pocket for Part D prescriptions **only**
- Payments by any of the following programs or organizations:
  - Extra Help from Medicare
  - Coverage Gap discounts from manufacturers
  - Indian Health Service
  - AIDS Drug Assistance Program
  - Most charities
  - State pharmaceutical assistance programs (SPAPs).

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.

As your TrOOP cost increases, you will shift to different coverage stages. **Once you hit the 2021 MOOP cost, you will stop paying for covered prescription drugs, no matter the stage you are in.**

The amount you pay for covered prescription drugs depends on the tier your drug is in (as shown below) and your coverage stage.

Stage One Initial Coverage Limit: $200 deductible	You pay a $200 deductible. Once the deductible is met, you pay coinsurance for covered prescription drugs: 5% generic, 20% brand or 30% nonpreferred brand
Stage Two Coverage Gap: $4,130–$6,550	You continue to pay coinsurance for covered prescription drugs: 5% generic, 20% brand or 30% nonpreferred brand, until you reach the $3,500 MOOP
Stage Three Catastrophic Coverage: $6,550	If your True Out-of-Pocket (TrOOP) cost reaches $6,550, you're responsible for up to 5% of the cost or $3.70 for generics and $9.20 for brand prescription drugs, whichever is greater, until you reach the $3,500 MOOP for drugs

* Annual prescription drug deductibles will ***not*** be prorated if you enroll mid-year.

NOTE: Certain prescription drugs, including immunosuppressive drugs, clotting factors, drugs for dialysis and antigens, are covered under your medical coverage. You will pay a $10 copay for these drugs. Contact Anthem for more information.

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 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.

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 **express-scripts.com** or **ct.gov**.

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, Express Scripts Medicare will notify you before the change.

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.

Prior authorization. Your health care provider must get prior authorization from Express Scripts Medicare for certain drugs. If Express Scripts Medicare approves your request for an exception, you will pay the nonpreferred brand cost share for that drug.

Finding In-Network Retail Pharmacies

You must use participating Express Scripts Medicare network pharmacies to fill your prescriptions. To find a network pharmacy, call Express Scripts customer service (**866.477.5703**; TTY: **800.716.3231**) or visit **express-scripts.com**.

You can only use out-of-network pharmacies in special circumstances, such as emergencies. If you do, you must pay the full cost and submit your receipts for reimbursement.

Mail Order Pharmacy

Maintenance medications—those that you take long term, typically for a chronic condition—can be filled through the mail order pharmacy. You'll receive a 90-day supply shipped directly to your home, with free standard shipping. Plus, you can refill them from Express Scripts' website or mobile app. **NOTE:** Not all prescriptions are available for a 90-day supply.

To enroll, visit **express-scripts.com** and look for medications that indicate "Transfer to Home Delivery," add that medication to your cart, and complete the checkout process.

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.

Dental

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 free routine exams.

The dental plan covers routine exams at no cost to you!

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 will save you money, because they have agreed to accept Cigna's reimbursement.

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

If you go out of network for care, you must pay 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. 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 & 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.

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 **800.CIGNA24**.

Finding In-Network Providers

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

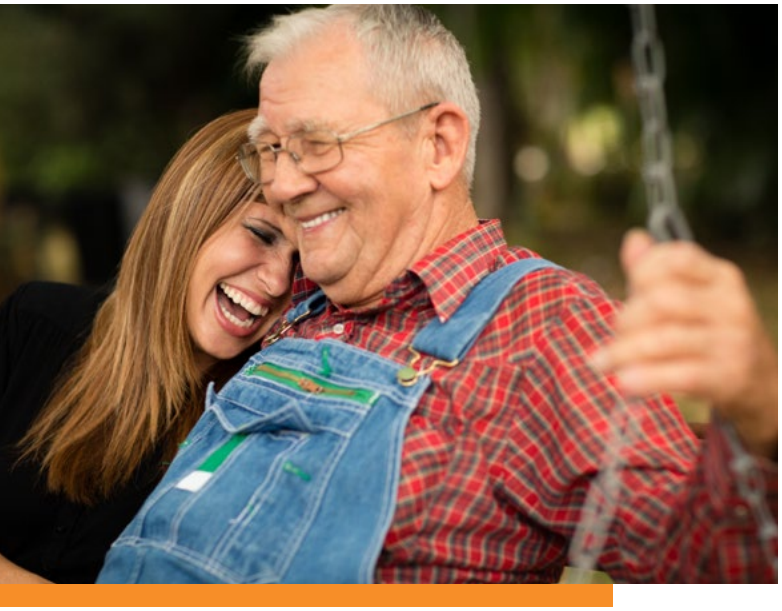
Vision

Vision benefits, administered by Anthem, are in addition to those provided under your medical coverage. (See page 13.)

Under the vision plan, you'll receive up to a $240 reimbursement every 24 months for covered vision expenses, including exams, frames, lenses and contacts.

Hearing

Hearing benefits, administered by Anthem are provided under your medical coverage. See page 13 for hearing benefit details.



Contact

For general questions about your benefits, contact the Connecticut Teachers' Retirement Board:

165 Capitol Avenue
Hartford, CT 06106
800.504.1102
ct.gov/trb

For benefit-specific questions:

Benefit	Contact	Phone	Website
Anthem Medicare Advantage Plan	Anthem	**833.607.6517** (TTY: 711), Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays	**anthem.com**
Anthem Medicare Supplement Plan	Anthem	**800.633.6673**	**anthem.com**
Prescription Drugs	Express Scripts Medicare	**844.433.4883**	**express-scripts.com**
Dental	Cigna Dental	**800.244.6224**	**cigna.com** or **mycigna.com**

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 (or when you fill a drug prescription).

Deductible. The amount you pay for covered medical services each plan year before the plan pays benefits. Once you've met the deductible, you share the cost of covered medical 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 January 1.

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 7 for plan enrollment.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