# STATE OF CONNECTICUT

## TRB SPONSORED
## MEDICARE SUPPLEMENT PLAN

## SUMMARY PLAN DESCRIPTION

**EFFECTIVE JANUARY 1, 2019**

**Administered by Stirling Benefits, LLC**

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# INTRODUCTION

This Booklet describes the Medicare Supplement health benefits plan provided as an option for members by the Connecticut Teachers' Retirement Board (TRB). In addition, it provides the vision and hearing benefits provided by TRB to plan members selecting this Medicare Supplement option.

To enroll in the plan the member must be enrolled in both Part A and Part B of Medicare and be a resident of the United States.

The TRB reserves the right to terminate, suspend, discontinue or amend the Plan at any time upon appropriate notice to Members. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, exclusions, limitations, definitions, eligibility and the like. If the Plan is terminated, the rights of Eligible Members are limited to covered charges incurred before termination.

This plan is a governmental self-funded plan. As such, the operation and administration of the plan is vested in the Teachers' Retirement Board.

# ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

## ►Eligibility Requirements

Eligible members include all of the following:

(1) A retired Medicare Part A and B participating Teacher receiving a retirement benefit, or disability allowance from the Connecticut Teachers' Retirement Board, or
(2) The spouse of a retired member, or
(3) The surviving spouse of a retired member, or
(4) A disabled dependent of a retired member when there is no spouse, or surviving spouse.
(5) You must be a legal resident of the United States to participate in our health benefits plan.

Plan eligibility is defined by Statute; the requirements listed above are a summary of the statutory language.

**Enrollment Requirements**. Qualified individuals must apply for coverage by filling an enrollment application. To be eligible for coverage the application should be received no later than the 25th day of the second month preceding the effective date of coverage.

Members under this program are all individuals as defined by statute. The plan provisions apply separately to each member. There are no family or two person memberships at TRB.

**When Coverage Terminates.** Coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.
(2) The last day of the month in which the member becomes ineligible.

A surviving Spouse ceases to be an Eligible Member upon remarriage. Spouse in this document is defined to include civil union partners as established by CT General Statutes.

A former spouse ceases to be an eligible member upon divorce or legal separation, unless they choose to elect COBRA coverage. The former spouse would be responsible for 102% of the cost of premiums and may continue the COBRA coverage for 36 months.

# PLAN OVERVIEW

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| **Provider access** | All providers who accept Medicare. |
| **Covered Benefits** | If Medicare covers a charge, then the TRB plan covers that charge. |
| **Medicare Deductible** | The 2019 deductible is $185. The member pays the Medicare Part B deductible. |
| **TRB Part B Plan Deductible and co insurance** | The 2019 TRB deductible is $500. Medicare usually pays 80% of allowed charges for non-hospital claims. The remaining 20% will apply to the TRB deductible until $500 is met. After the deductible is met the plan will pay 90% of Medicare covered charges, the member will pay 10% until they reach $500.00. |
| **Post TRB deductible and cost share** | The TRB plan generally pays 100% of a members out of pocket costs after the TRB deductible and cost share is met. |
| **Unassigned Benefits** | Most Medicare providers accept assignment. Providers that do not accept assignment may bill an extra 15% above what Medicare allows. The TRB plan pays 100% of the extra 15% for unassigned claims. |

# HOSPITAL BENEFITS

This Plan is designed to supplement Medicare Part A coverage for Hospital expenses. There will be no duplication of benefits for services reimbursable by Medicare.

### ►Inpatient Hospital Care

The Plan will pay the Medicare Part A Hospital deductible, less a $250 co-payment per admission for up to four admissions annually. ($1,000 maximum per calendar year.)

Medicare Part A provides 60 reserve days in a Lifetime. During these reserve days, this

Plan pays the portion of Medicare approved expenses not paid by Medicare.

When an Eligible Member has exhausted all Medicare Hospital benefit days (including any Lifetime reserve days) this Plan will, subject to prior approval, pay the UCR cost of a General Hospital Semi-private room, meals; general nursing care; and all hospital special services, for up to 60 additional days per year. This benefit applies when the annual and Lifetime reserve days have been exhausted for the Medicare approved admission.

### ►Inpatient Skilled Nursing Facility Care

This plan will cover expenses listed below (for up to 120 days) if all the following conditions are met:

(1) The facility is a Medicare-participating Skilled Nursing Facility, and
(2) The patient's condition requires daily skilled nursing or skilled rehabilitation services, and
(3) The patient has the Skilled Nursing Facility care benefit approved by Medicare, and
(4) Care in the facility is for the same condition that was treated in the Hospital, and
(5) A medical professional certifies that the patient needs, and receives, skilled nursing or skilled rehabilitation services on a daily basis, and
(6) The facility must not be a place primarily for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, custodial care, or acute inpatient level of care, and
(7) Care in the facility is not primarily for custodial care, and
(8) Once Medicare has exhausted their benefits, approval must be obtained from Stirling Benefits prior continuation of benefits post Medicare.

Medicare Part A covers in full the first 20 days of care in a participating facility. This plan pays the co-insurance not paid by Medicare Part A subject to the plans deductible and cost share provisions, for the next 80 days, provided the admission is approved by Medicare. Then this plan will reimburse for an additional 20 days at the Medicare rate. The additional 20 days that exceeds the Medicare Benefit requires preauthorization by Stirling Benefits. The maximum covered stay under this plan is 120 days per benefit period.

Prior Approval of Hospital and Skilled Nursing Facility Services that exceed Medicare stay allowances are required under this plan. Failure to obtain prior approval will result in a denial of services that require such approval. To verify eligibility or to obtain approval for benefits before the charge is incurred call Stirling Benefits.

# BASIC MEDICAL BENEFITS

The Plan supplements Medicare Part B for Medical expenses. There will be no duplication of benefits for services reimbursable by Medicare.

Medicare Part B helps pay for:

(1) Medical and surgical service provided in a Physician's office, in a Medical Facility, in a patient's home or any other location

(2) Diagnostic tests;

(3) Radiology and pathology services by Physicians while and Eligible Member is a Hospital inpatient or outpatient;

(4) X-rays, MRI procedures and other imaging procedures;

(5) Drugs and Biologicals that cannot be self-administered;

(6) Durable Medical Equipment;

(7) Chiropractic Care and Therapy services;

(8) Diabetic Supplies: Including Test strips, Lancets and Monitors.

**A Medicare Calendar Year deductible and a $500 plan deductible are applied prior to any service under Part B. This Plan does not cover the annual Medicare deductible.**

After the Medicare Calendar Year deductible and the plan deductible are met, this Plan will apply the co-insurance balance (usually 20%) of the amounts approved by Medicare including the unassigned portion of the claim for the covered services to the TRB deductible. After the deductibles are met, the member and this plan share equally the patient responsibility until the TRB coinsurance share total is met. After the Medicare deductible, TRB deductible and TRB cost share is met, then this plan covers in full patient balances after Medicare has paid their share on charges covered by Medicare.

**Diabetic Supplies (Test Strips, Lancets, and Monitors)** are Covered under Part B of Medicare. In most cases the plan will pay a part or all of the remaining costs.

**Assignment of Claims**

Under Medicare Part B, medical providers either assign benefits to Medicare or provide services as an unassigned provider. The majority of providers assign benefits. When benefits are assigned, the provider agrees to accept as full payment the amount that Medicare allows for that service. Medicare pays the provider and so does Stirling Benefits.

When benefits are not assigned, the provider is entitled to receive up to an additional 15% above what Medicare allows. Medicare pays the member, the TRB plan pays the member, and the member pays the provider. This plan pays the additional 15% for unassigned claims in full after the application of the TRB deductible or cost shares.

# ADDITIONAL BENEFITS NOT COVERED UNDER MEDICARE PART A OR PART B

This Section is designed to supplement Medicare Parts A and B There will be no duplication of benefits covered by Medicare.

**Out of Country**

This Plan will pay for emergency and acute care that occurs while traveling outside of the United States. Payment is limited to a lifetime amount of $100,000 for out of country services. Circumstances of the illness/injury must be submitted along with the claim, and charges must be converted to US currency. The payment amount is limited to the charges that would be billed on behalf of a local resident in the country where the service is rendered. The bill must be paid by the member upon discharge from the hospital.

For acute care, this plan will only pay the percentage that the Plan would have paid if the medical procedure was covered in the United States. For example, this plan will pay 20% of the allowed charge for an office visit and 0% for a lab charge for services provided outside the United States and its territories or possessions. This Plan does not cover routine care or care for chronic conditions while a person is not a resident of the United States. The Out of Country benefit may not be used to obtain care that is not covered by Medicare.

**Out of Country Inpatient Hospital Care**

For acute or emergency care, this Plan will cover 30 days semi-private room for an Inpatient Hospital stay for illness/injury while traveling outside of the United States. Payment out of country is limited to a lifetime maximum amount of $100,000. Circumstances of the illness/injury must be submitted along with the claim, and charges must be converted to US currency.

The payment amount is limited to the charges that would be billed at the local market price in the country where the benefit was received. The member upon discharge must pay the bill from the hospital. Benefits are not available outside of the United States for permanent residents of countries other than the United States. The Out of Country benefit may not be used to obtain care that is not covered by Medicare.

**►Covered Charges**

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply not already provided in Medicare or the Basic Benefits of this Plan. These charges are subject to the "Benefit Limits" of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) Veterans Benefits
Medicare does not cover services from Veterans Affairs (VA) hospitals or other VA facilities. However, this plan will pay the members' balance up to the amount that it would have paid if the charge was considered by Medicare.

(2) Prescription Wigs after chemotherapy up to $500 maximum in a two-year period.

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| Medical Nutritional Therapy- up to 3 one hour visits | 100%; must meet specified conditions | N/A | $0 |
| Obesity screenings & counseling | 100% if BMI of 30 or more | N/A | $0 |
| Prostate Cancer Screening Exam - once every 12 months | 100% once every 12 months | N/A | $0 |
| Yearly "Wellness" visit | 100% each 12 months | N/A | $0 |
| Emergency and Urgent Care Outside of the US - Foreign Travel | Medicare does not cover care outside the US and Puerto Rico | 100% inpatient hospital up to 30 days; 80% life threatening outpatient; 20% non-life threatening outpatient | Remaining balance after plan allowed amounts. |

# SCHEDULE OF BENEFITS

| Medicare Part A<br>Inpatient and Skilled Nursing Services | | | |
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| | **Medicare Covers** | **TRB Medicare Supplement Plan Covers** | **Member Pays** |
| Hospital inpatient stays | Medicare payment varies by length of stay and use of Medicare reserve days | All expenses approved by Medicare, less a $250 copayment per admission for the first 4 admissions per year. 100% thereafter | $250 per hospital admission for the first four admissions. Member pays $0 for any hospital admission after the first four per year. |
| Extended Hospital Stays | Medicare covers the first 90 days of a hospital admission, and also has 60 lifetime reserve days | If Medicare hospital benefits are exhausted, the plan covers 100% of the cost for an additional 60 days per admission | No cost for an additional 60 days per admission after Medicare benefits are exhausted. |
| Skilled Nursing Benefit | 100% of the first 20 days paid | $0 | $0 |
| Skilled Nursing Benefit | A daily copayment for the next 80 days | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Skilled Nursing Benefit | $0.00 for the next 20 days | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Home Health Care | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Home Health Care-Aide | Limited benefits | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |

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| Hospice Care | Medicare pays in full | $0 | $0 |

| **Medicare Part B Outpatient Services**<br>**Subject to Part B deductible $183, $500 annual Plan deductible, coinsurance 90% paid by plan, 10% paid by member not to exceed $1000 per year** | | | |
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| | **Medicare Covers** | **TRB Medicare Supplement Plan Covers** | **Member Pays** |
| Primary Care visit | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Specialists | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Surgery | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Emergency Care | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Ambulance | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Urgent Care | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Physical, Speech, Occupational and Cardiac Therapy | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Annual Routine Vision Exam | $0.00 | Up to $75 once per year. No network, any provider. | any costs in excess of $75 |

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| Diagnostic Vision & Hearing Exams | 80% of the allowed amount if covered by Medicare | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Hearing Aids- | Medicare does not cover | $750 allowance every three years | Costs in excess of $750 |
| Chiropractor | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| DME/Prosthetics | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Diabetes Monitoring Supplies | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Medicare Part B drugs | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Outpatient Mental Health and substance abuse | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Lab and X-ray, MRI, CT and other diagnostic testing | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Radiation therapy | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |
| Kidney Dialysis | 80% of the allowed amount | 100% of the cost after satisfaction of the TRB deductible and cost share | $0.00 after satisfaction of the TRB deductible and cost share |

| Medicare Routine Care | | | |
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| | **Medicare Covers** | **TRB Medicare Supplement Plan Covers** | **Member Pays** |
| Cardiovascular Disease Screening | 100% once every 5 years | N/A | $0 |
| Cervical and Vaginal Cancer Screening (Pap test and pelvic exam) | 100% every 24 months; once every 12 months if high risk | N/A | $0 |
| Colorectal Screening - every 10 years if not high risk | 100% once every 120 months; once every 24 months if high risk | N/A | $0 |
| Diabetes Screening | 100 % up to 2 screenings each year | N/A | $0 |
| Flu Vaccination and Administration- Some Vaccines are covered under your Part B benefit | 100% one flu shot per flu season | N/A | $0 |
| Hepatitis B Virus (HBV) infection screening | 100% if you are high risk | N/A | $0 |
| Hepatitis C screening test | 100% yearly if you are high risk | N/A | $0 |
| HIV screening | 100% if you are high risk | N/A | $0 |
| Lung cancer screening | 100%; must meet specified conditions | N/A | $0 |
| Mammogram | 100% once every 12 months | N/A | $0 |

# VISION CARE BENEFITS

Routine Eye exam, for purposes of refraction, per person, in a 12 month period $75

Frame-type lenses, per pair, in a 24-month period:

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| Single vision. | $60 |
| Bi-focal | $80 |
| Tri-focal | $120 |
| Lenticular | $200 |
| Frames, per pair | $100 |
| Contact Lenses | $120 (every 12 months) |

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

**►Benefit Payment**

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

**►Vision Care Charges**

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

**►Limits**

No benefits will be payable for the following:

(1) Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) Charges excluded or limited by the Plan as stated in this document.

(3) Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) Charges for lenses ordered without a prescription.

(5) Charges for orthotics (eye muscle exercises).

(6) Charges for safety goggles or sunglasses, even if prescribed for a medical condition, including prescription type.

(7) Charges for vision training or subnormal vision aids.

# HEARING CARE BENEFITS

Hearing Aids, including attenuators, (includes fittings and adjustments) every 36 months $750.

Hearing care benefits apply when charges are incurred by a Covered Person for the purchase of a hearing aid and any related fittings and adjustments.

**►Benefit Payment**

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

**►Hearing Care Charges**

Hearing care charges are the Usual and Reasonable Charges for the hearing care services shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum amounts shown in the Schedule of Benefits for each hearing care service or supply.

**►Limits**

No benefits will be payable for the following:

(1) Treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) Charges excluded or limited by the Plan design as stated in this document.

(3) Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) Charges for routine hearing exams are not covered under this plan.

(5) Charges for hearing aid batteries are not eligible under this plan.

# DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Amounts-** approved are those amounts determined as usual and customary for covered services by the carrier or intermediary administering Part B of the Medicare program.

**Calendar Year-** means January 1st through December 31st of the same year.

**Cost Share or Coinsurance-** is an amount of patient responsibility that is shared between the member and the Plan. The TRB cost share is 50% member payment and 50% plan payment until the both the member and the plan each pay $500. The TRB Cost Share applies to charges approved by Medicare after the TRB deductible is met.

**Custodial Care-** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

**Deductible-** is an amount that the member pays prior to the plan payment. This plan has two deductibles that impact member responsibility. Medicare has a deductible amount that typically changes each year. The TRB plan has a $500 deductible. The TRB deductible typically applies to non-hospital expenses and Part B drug claims.

**Eligible Member-** includes all of the following who are enrolled in Medicare Part A and Part B

(1) A retired member receiving retirement or disability benefits from the Connecticut Teachers' Retirement Board; or

(2) A Spouse of a retired member or a surviving Spouse of a retired member. A surviving Spouse ceases to be an eligible member upon remarriage.

**Experimental and/or Investigatory**- means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

(1) The technology must be appropriate, in level of service and intensity, to the nature of the disease or condition being treated.

(2) Public policy would support the procedure(s) as a valid and ethical course of treatment.

(3) The technology is judged to be reasonably clinically effective according to reports in peer reviewed scientific literature, completed clinical study data and/or preponderant expert medical opinion.

If a technology does not meet the above criteria, in whole or in significant part, it will be deemed Experimental and/or Investigational. The decisions of the Plan Administrator will be final and binding on the Plan. Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Home Health Care Agency**- is an agency that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Hospital**- is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

**Injury-** means an accidental physical injury to the body caused by unexpected external means.

**Lifetime-** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Eligible Member.

**Medical Care Facility-** means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

**Medical Emergency**- is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that required immediate medical attention to prevent loss of life, loss of a limb or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.

**Medically Necessary**- care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider; is not conducted for research purposes; and is the most appropriated level of services which can be safely provided to the patient.

**Medicare-** is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Outpatient Care**- is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Physician-** means a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Psychologist (PhD), Licensed Professional Physical Therapist, Physiotherapist, Licensed Professional Counselor, Psychiatrist, Audiologist, Speech Language Pathologist, Midwife and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan Year**- is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year, which is a short Plan Year.

**Prescription Drug** - A human drug that is not safe for use except under the supervision of a licensed medical practitioner.

**Prior Approval** - Certain services and drugs paid for under this plan are subject to prior approval requirements. If approval is not obtained prior to the admission or provision of the service and/or supply or drug, then no benefit is payable. In the case of life threatening emergency admissions, approval may be granted up to two days after the admission or provision of service, supplies or

drugs and notice will be considered timely. The plan administrator (Stirling Benefits) must be contacted by the member for approval of services.

**Sickness-** is a person's illness.

**Skilled Nursing Facility-** is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons with Injuries or Sickness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

(8) Prior approval for the services has been provided by Stirling Benefits.

**Teacher-** is used as described he Connecticut General Statutes section 10-T.

**Usual and Reasonable Charge**- is an amount determined as usual and customary for covered services by the carrier or intermediary administering Part B of the Medicare program.

# PLAN EXCLUSIONS

**Note: For specific information about prescription drug or dental exclusions under these plans, please refer to the other plan materials you will receive from the Pharmacy and Dental Benefits Manager.**

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered, unless the charge or services is covered by Medicare at the time the charge was incurred:**

(1) Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) Charges excluded by the Plan as mentioned in this document.

(3) Charges incurred for which the Member or Plan has no legal obligation to pay.

(4) Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(5) Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Eligible Member is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or Sickness.

(6) Care and treatment for which there would not have been a charge if no coverage had been in force.

(7) Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(8) Care and treatment that is either Experimental/Investigational or not Medically Necessary

(9) The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge as determined in the sole discretion of the Plan administrator.

(10) Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

(11) Professional services performed by a person who ordinarily resides in the Member's home or is related to the Member as a spouse, parent, child, siblings, whether the relationship is by blood or exists in law.

(12) Radial keratotomy or other eye surgery to correct near-sightedness. Also, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(13) Hearing aids and exams for their fitting. Coverage provided under the Hearing benefits rider are considered eligible when incurred while covered.

(14) Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy related condition, which is known or reasonably suspected.

(15) Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(16) The following care, treatment or supplies for the feet: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; and treatment of corns, calluses or toenails, unless needed in treatment of a metabolic or peripheral-vascular disease.

(17) Services for educational or vocational testing or training.

(18) Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(19) Personal comfort items or other equipment, such as, but not limited to, air conditioners, air purification units, humidifiers, allergy free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, most nonprescription drugs and medicines, and first aid supplies and nonhospital adjustable beds.

(20) Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(21) Exercise programs for treatment of any condition.

(22) Care and treatment billed by a Hospital for non-Medical Emergency admission on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(23) Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(24) All claims must be submitted to Medicare first. If a charge is ineligible or denied by Medicare, it will not be covered under this Plan. Claims from Providers that have "opted out" of Medicare are not eligible for reimbursement under this plan.

(25) Care, service, supplies or drugs for which prior approval was required but was not obtained.

(26) Chiropractic Modalities not covered by Medicare.

# HOW TO FILE A CLAIM

Since all of your Hospital and medical claims must be submitted to Medicare first, it is important that you give your Medicare number to the provider.

Vision and hearing claims must be filed directly with Stirling Benefits within one year of the date of service.

Hospitals, Skilled Nursing Facilities, Home Health agencies and Hospices are called providers, and they submit their claims directly to Medicare. When you show the provider your Stirling Benefits identification card, the provider will typically bill Stirling Benefits for any balance not covered by Medicare. It is possible that some providers may ask you to send us the bill for any balance. They will give you a notice of utilization, which explains the decision Medicare made on the claim.

Physicians, suppliers and other providers of medical services are in most cases required to submit Medicare claims for you. In most cases the Medicare, intermediary or carrier will send an explanation of your Medicare Part B benefits to Stirling Benefits and your Plan will send you a check for the proper balance. If your Physician does not accept assignment, you may be billed for an additional amount.

In some cases, the Medicare carrier may send the explanation of Medicare benefits directly to you. Keep a copy for your records. In most cases, the Medicare carrier has also sent a copy to Stirling Benefits which will process your claim.

Some expenses are not eligible for Medicare but may be covered under the Major Medical part of your Plan. These include charges incurred outside of the United States and skilled nursing stays exceeding 100 days.

**Time Limit For Filing Claims.** Claims must be submitted to Stirling Benefits no later than three months after Medicare's time limit.

# COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans including Medicare are paying.

a) This Plan always pays secondary to Medicare.

b) Coverage provided through active employment, including coverage as a dependent on a plan where the spouse is an active employee, pays first.

c) Plans that cover the member as a retiree pay before plans that cover the member as a spouse or surviving spouse of a retiree.

**Automobile Limitations.** When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

**Claims Determination Period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to Receive or Release Necessary Information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. An Eligible Member will give this Plan the information it asks for about other plans and their payment of allowable charges.

**Facility of Payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of Recovery.** This Plan may pay benefits that should be paid by Medicare or another benefit plan. In this case, this Plan may recover the amount paid from Medicare, the other benefit plan or the Eligible Member. That repayment will count as a valid payment.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

# THIRD PARTY RECOVERY PROVISION

**►Right of subrogation and Refund**

**When this provision applies.** The Eligible Member may incur medical charges due to Injuries for which benefits are paid by the Plan. The Injuries may be caused by the act or omission of another person. If so, the Eligible Member may have a claim against that other person for payment of the medical charges. The Plan will be subrogated to all rights the Eligible Member may have against that other person.

The Eligible Member must:

(1) Assign to the Plan his or her rights to recovery when this provision applies; and

(2) Repay to the Plan out of the recovery made from the other person or the other person's insurer.

**Amount subject to subrogation or refund.** Only the amount recovered for medical charges will be subject to subrogation or refund. In no case will the amount subject to subrogation or refund exceed the amount of medical benefits paid for the Injury or Sickness under the Plan.

When a right of recovery exists, the Eligible Member will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the right of subrogation. In addition, the Eligible Member will do nothing else to prejudice the right of the Plan to subrogate.

**Defined terms:** "Recovery" means monies paid to the Eligible Member by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries.

"Subrogation" means the Plan's right to pursue the Eligible Member's claims for medical charges against the other person.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury.

**Recovery from another plan under which the Eligible Member is covered.** This right of refund also applies when an Eligible Member recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

# GENERAL PLAN INFORMATION

**TYPE OF ADMINISTRATION:** The Plan is a self-funded Medicare Supplement Plan and the administration is provided through a third party Claims Administrator.

**PLAN NAME:** Connecticut Teachers' Retirement Board Health Benefits Plan

**PLAN EFFECTIVE DATE:** This description is effective January 1, 2019.

**PLAN YEAR ENDS:** December 31st.

**MEDICARE SUPPLEMENT**
**MEDICAL CLAIMS ADMINISTRATOR**
Stirling Benefits, Inc.
20 Armory Lane
Milford, CT 06460-3361 (800) 447-6689 www.stirlingbenefits.com

**PLAN SPONSOR INFORMATION**
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