



CT TEACHERS' RETIREMENT BOARD
765 ASYLUM AVENUE HARTFORD, CT 06105-2822
Toll free 1-800-504-1102 X8411 or X8432 (860) 241-8411 or (860) 241-8432 Fax (860) 622-2849
"An Affirmative Action/Equal Opportunity Employer"
www.ct.gov/trb

**October 2013
Premium Notification and TRB Health Insurance Change Form
Effective January 1, 2014**

Premium Change Notification

Monthly Premium Per Person

<u>Coverage Type</u>	<u>2013</u>	<u>2014</u>
Medicare Supplement with Prescriptions*	\$117.00	\$97.00
Medicare Supplement with Prescriptions & Dental	\$160.00	\$141.00
Medicare Supplement with Prescriptions, Dental, Vision & Hearing	\$165.00	\$146.00

*This plan is the base plan available through the Teachers' Retirement Board. The full cost for the base plan in 2014 is \$291 monthly per person. Two-thirds of the base plan cost is subsidized on your behalf (\$194). The plan participant pays one-third of the premium (\$97).

Change in Coverage Form: This is your annual opportunity to modify your coverage selection. To make a change, you must submit the appropriate change form on or before November 15, 2013. If you are not making a change, do not submit the enclosed form(s). On January 1, 2014 you are locked into your plan through December 31, 2014, unless you cancel all coverage.

Important Mail Order Early Refill Rule Change:

Effective January 1, 2014, mail order drugs can be refilled 72 days after the last refill of your 90 day supply was mailed. Previously this could be done at 60 days after the last refill was mailed.

Diabetic Supplies (Test Strips, Lancets, and Monitors) are available through a retail pharmacy or through a diabetic supply company. Claims should be submitted through both Medicare and Stirling Benefits, as these items are not covered under your pharmacy benefits program.

- The cost of prescriptions varies from one pharmacy to another, therefore, if you use a retail pharmacy we encourage you to shop around.
- Caremark fills mail order prescriptions received directly from your physician when they receive the script, regardless of whether you are aware of or have approved the order. Allow up to four weeks for processing when you submit the initial order yourself. If your physician changes your prescription, you should obtain confirmation from Caremark that the original prescription will be cancelled. A change in dosage does constitute a prescription change.
- We receive a federal reimbursement for sponsoring a prescription program for retirees who are enrolled in Medicare. **We do not allow participation in our prescription program if you are participating in a Medicare D prescription program, a Medicare advantage program, or the prescription program of another plan sponsor who receives the federal reimbursement.** To find out if another prescription program receives the federal reimbursement contact the benefits department of the other plan sponsor. In the event we learn that you are participating in a federally subsidized program apart from this one while enrolled in this one, we will cancel your prescription plan from this system and provide you with notification. You will remain in your TRB health

coverage but will be dropped from your TRB prescription coverage. There will be no refund or reduction to your TRB premium.

- A spouse is not eligible for TRB coverage upon divorce or legal separation. In the event a former spouse is participating in the TRB sponsored health insurance plan, the member must inform TRB and provide a copy of the legal separation or dissolution of marriage as soon as possible.
- A surviving spouse is not eligible upon remarriage. Prompt notification is necessary to avoid running into a reimbursement of paid claims situation after eligibility ends.
- TRB changes addresses on the 1st working day of each month. Therefore, you must submit address changes in writing including your signature directly to TRB at the above address prior to the 1st working day of each month to ensure as little disruption as possible in the delivery of service and claim processing.
- ID cards are mailed shortly before the effective date of your coverage directly from the individual vendors.
- New Medicare Card with New Medicare Number: If for any reason you are issued a Medicare card with a new Medicare number, make a copy of that card and mail to the above address with a notation "New Medicare Number". Often, the only difference is the letter at the end of the Medicare number. Failure to furnish your new card could result in a disruption of benefits or claims processing.

The Health & Prescription Drug Benefits Plan Summary is available on our website at:
<http://www.ct.gov/trb/lib/trb/formsandpubs/SPD-WEB.pdf>.

PLAN SPONSOR INFORMATION

Connecticut Teachers' Retirement Board
765 Asylum Avenue
Hartford, Connecticut 06105-2822
Direct-Dial (860) 241-8411
Toll-Free (800) 504-1102 <http://www.ct.gov/trb>

MEDICAL CLAIMS ADMINISTRATOR

Stirling Benefits, Inc.
20 Armory Lane
Milford, Connecticut 06460-3361
(800) 447-6689 <http://www.stirlingbenefits.com/>

PRESCRIPTION DRUG SERVICES

CVS Caremark
PO Box 94467
Palatine, IL 60094-4467
e-mail customerservice@caremark.com
(877) 906-3802 <https://www.caremark.com>

DENTAL CLAIMS ADMINISTRATOR

Aetna Dental PPO II
151 Farmington Avenue
Hartford CT 06156
(855) 394-3874 <http://www.aetna.com>



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Health Insurance Change Form Member

This form is to be used by a member who is currently enrolled in the Teachers' Retirement Board Health Plan who is either adding or dropping the dental or vision and hearing coverage. **Do not submit an application if you are not changing your coverage.**

- Submit a copy of your Medicare Card if you are making a change to your coverage.
- Due Date for those making changes is November 15, 2013.
- Your change will become effective January 1, 2014.

	Cost per person per month	Check one(x)
Medicare Supplement with Prescriptions	\$97.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental	\$141.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	\$146.00	<input type="checkbox"/>

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name First Name Initial			Home Phone	
Street Address City State Zip Code			Email Address	
Social Security #	Medicare Number		Date of Birth	
Enrollee's Signature			Date	



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**Health Insurance Change Form
 For Spouse, Surviving Spouse or Civil Union Partner**

This form is to be used by the spouse, surviving spouse or civil union partner of a retiree who is currently enrolled in the Teachers' Retirement Board Health Plan who is either adding or dropping the dental or vision and hearing coverage. Do not submit an application if you are not changing coverage.

- Submit a copy of your Medicare Card if you are making a change to your coverage.
- Due Date for those making changes is November 15, 2013.
- Surviving spouses become ineligible upon remarriage
- Spouses are ineligible for coverage upon divorce or legal separation.
- Your change will become effective January 1, 2014.

	Cost per person per month	Check one(x)
Medicare Supplement with Prescriptions	\$97.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental	\$141.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	\$146.00	<input type="checkbox"/>

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name First Name Initial			Home Phone		
Street Address City State Zip Code				Email Address	
Social Security #		Medicare Number		Date of Birth	
Enrollee's Signature			Date		

Also please furnish the following:

Retired Teacher's Name	Retired Teacher's Social Security #	Retiree's Signature
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