

CONNECTICUT



TRB SPONSORED HEALTH PLANS

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2017

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INTRODUCTION

Your (our) health benefits plan provided by the Connecticut Teachers' Retirement Board contains four separate sections. The services covered under each of these sections are detailed in this Summary Plan Description as follows:

Section A - Basic Hospital Benefits

Section B - Basic Medical Benefits

Section C - Major Medical Benefits

Section D - Prescription Drug Benefits

These sections are followed by a description of the Dental, Vision and Hearing coverage.

In order to be enrolled in this plan, you must be enrolled in both Part A and Part B of Medicare and be a resident of the United States.

New enrollees to our health benefits plan will only be offered the health care coverage as a single package consisting of Hospital, Medical, Major Medical, Prescription Drug Benefits and Dental, Vision & Hearing. Existing members are grandfathered into their current coverage.

The prescription drug coverage is an Employee Group Waiver Plan (EGWP) which is an enhanced group sponsored Medicare Part D prescription drug plan. As the prescription drug plan receives federal funding, you are not allowed to participate in another Medicare D prescription program, a Medicare advantage program, or the prescription drug program of another plan sponsor who receives the federal reimbursement. If we are notified that you are participating in another prescription plan subsidized and/or paid for by the federal government all of your health care coverage through the TRB will be terminated.

Effective January 1, 2017, Cigna will be your new Dental Claims Administrator. The maximum per member annual dental limit is \$2,500.

The Connecticut Teachers' Retirement Board fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time upon advance notice to all Eligible 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.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

► ELIGIBILITY REQUIREMENTS

Eligible members include all of the following who are enrolled in Medicare Part A and Part B:

- (1) A retired member 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.

Enrollment Requirements. An Eligible Member must enroll for coverage by filling out and signing an enrollment application. The application must be sent to the CT Teachers' Retirement Board, 765 Asylum Avenue, Hartford, Connecticut 06105. Such enrollment application should be received no later than the 25th day of the second month preceding the effective date of coverage.

Effective Date of Member Coverage. An Eligible Member will be covered under this Plan on the first day of the month providing enrollment requirements are met. Enrollment applications must be received by the 25th of the month plus one intervening month before coverage may become effective. For example, for July 1 coverage, an enrollment application must be received by May 25.

ID cards are mailed under separate cover shortly before the effective date of your coverage directly from the individual vendors.

All deductibles apply to each covered member.

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.
- (3) The last day of the month that the premium was paid.

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 100% of the cost of premiums and may continue the COBRA coverage for 36 months.

SCHEDULE OF MEDICAL BENEFITS

Verification of Eligibility or Prior Approval of Hospital and Skilled Nursing Facility Care Services.

To verify eligibility or to obtain approval for benefits before the charge is incurred call Stirling Benefits.

SECTION A - BASIC HOSPITAL BENEFITS

This Section is designed to supplement Medicare Part A 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.

Medicare Part A provides a benefit period of 90 days. Medicare pays approved expenses in full during the first 60 days of a benefit period. This Plan will pay the share of approved expenses from the 61st day to the 90th day of a benefit period not paid by Medicare Part A.

Medicare Part A provides 60 reserve days in a Lifetime. During these reserve days, this Plan pays the portion of approved expenses not paid by Medicare.

Once an Eligible Member has exhausted all Medicare Hospital benefit days (including the Lifetime reserve days) this Plan will, subject to prior approval, pay the cost of a General Hospital Semi-private room; meals; general nursing care; and all hospital special services, for up to 60 additional days. This benefit applies when the annual and Lifetime reserve days have been exhausted for the Medicare approved admission. Additional days are not available for nervous-mental conditions.

► Inpatient Skilled Nursing Facility Care

This plan will cover expenses listed below (for up to 120 days) only 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 been in a Hospital at least three days in a row (not counting the day of discharge), and
- (4) The patient is admitted to the skilled nursing facility within 30 days of release from the Hospital, and
- (5) Care in the facility is for the same condition that was treated in the Hospital, and
- (6) A medical professional certifies that the patient needs, and receives, skilled nursing or skilled rehabilitation services on a daily basis, and
- (7) 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
- (8) Care in the facility is not for custodial care, and
- (9) Approval has been obtained from Stirling Benefits prior to admission to the facility.

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 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, no additional coverage is provided under the Major Medical section of this policy.

► Home Health Aide Services

This Plan will pay up to \$500 per Calendar Year, provided all the following conditions are met:

- (1) The services are provided by a certified home health aide who is employed by a Home Health Agency licensed by the State of Connecticut or the State governing the agency,
- (2) The attending Physician has certified in writing that the services are Medically Necessary,
- (3) Limited to 4 hours per day,
- (4) The services are not reimbursable by Medicare,
- (5) Patient must be homebound.

SECTION B - BASIC MEDICAL BENEFITS

This Section is designed to supplement 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.

Before Medicare pays for any of the above expenses, a Calendar Year deductible is applied. This Plan will not cover the deductible.

This Plan will pay the co-insurance balance (usually 20%) of the amounts approved by Medicare for the covered services after the Calendar Year deductible.

The Plan will provide coverage for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Medicare Part B.

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.

SECTION C - MAJOR MEDICAL BENEFITS

This Section is designed to supplement Medicare Parts A and B and the Basic Benefits listed above. There will be no duplication of benefits covered by Medicare Plan.

The Plan pays 80% of covered expenses and the member pays 20% of covered expenses

Maximum Benefit Amounts

Lifetime, while covered \$1 million

► Benefit Limits

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 combined with the out of country Inpatient Hospital Care. Circumstances of the illness/injury must be submitted along with the claim, and charges must be converted to US currency. 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 lives outside the United States, even if their stay is for less than one half the year. The Out of Country benefit may not be used to obtain care that is not available within the United States.

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 is limited to a lifetime amount of \$100,000 combined with the out of country Major Medical benefit. Circumstances of the illness/injury must be submitted along with the claim, and charges must be converted to US currency. 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 available within the United States.

Outpatient Physical/Speech and Occupational Therapy

Percentage payable same as for other Medicare approved Sickness

► 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) Private Duty Nursing Care

- (a) Services provided in or outside a Hospital by an actively practicing registered nurse (RN) or a licensed practical nurse (LPN). This care must require the continual skill of a RN or LPN in accordance with a Physician's (MD) prescribed plan of care. Coverage for any one RN or LPN will be limited to 8 hours in each continuous 24-hour period (i.e., day).
- (b) Nursing Services require prior approval from Stirling Benefits prior to the beginning of a course of care.
- (c) The maximum coverage under this program is for a lifetime total of 200 days for

nursing or visiting nurse services. These services must be at a level of acuity so that the care is provided in lieu of a hospital stay.

(2) 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.

(3) Outpatient Physical/Speech and Occupational Therapy

This plan will provide Therapy services after the Medicare maximum has been met, up to an amount equal to the annual Medicare maximum, if the following materials are received:

- (a) Copy of physician's referral indicating medical necessity,
- (b) Treatment plan including the projected number of treatments and length of treatment program,
- (c) Approval has been obtained from Stirling Benefits prior to the beginning of treatment.

(4) Prescription Wigs after chemotherapy \$500 in a two year period.

► **Care for Mouth, Teeth, and Gums**

Charges for the care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

- (1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth,
- (2) Prompt repair of sound natural teeth (those which have not been subject to previous repair) required as a result of an accidental Injury while covered under this Plan. Injury as a result of chewing or biting will not be considered an accidental injury,
- (3) Surgery needed to correct accidental injuries to the jaw, cheeks, lips, tongue, floor and roof of the mouth when the Injuries occurred while covered under the Plan,
- (4) Excision of benign bony growths of the jaw and hard palate,
- (5) No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

SECTION D - PRESCRIPTION DRUG BENEFITS

The prescription drug benefits program is administered by Express Scripts (the plan's Pharmacy Benefits Manager). This Section is available to all Eligible Members.

► **Retail and Mail Order Pharmacy Options**

Because the deductible and out of pocket maximum change each year, the changes are posted to the TRB website. [The deductible](#) applies to the first expenses each year and is renewable each January 1st.

Coinsurance levels.....	<u>Cost to Member</u>
Generic drugs	0%
Preferred Brand drugs	20%
Non-Preferred Brand drugs.....	30%

The annual maximum out of pocket expense is the sum of deductible and coinsurance for covered prescription drug benefits. When a member's expenses exceed \$1,150, prescriptions will be filled at no charge to the member for the remainder of the year.

► **Generic Substitution Requirement**

All prescriptions for which there is a federally approved generic available will have the prescription filled with the generic substitute. The member may request that the prescription be filled with the brand name drug. If the member's physician finds that the brand name drug is medically necessary for reasons of allergic reactions or efficacy, the brand name drug will be provided and the member will be held responsible only for the coinsurance.

► **Options for Obtaining Maintenance Drugs**

Drugs identified by the Pharmacy Benefit Manager as maintenance drugs may be obtained either through the mail order vendor or from a participating retail pharmacy.

Diabetic-Insulin and Syringes are covered by the Prescription Drug Benefit Plan.

► **Limits to the Benefits**

The benefits under this section apply only when an eligible member incurs a charge for covered prescription drugs. The coverage is limited to:

- (1) Refills up to the number of times specified by the Physician,
- (2) Refills up to one year from the date of order by a Physician. If the drug is a controlled substance, the refill period will be limited to the initial fill plus 5 additional refills if allowed.

► **Expenses Not Covered**

- (1) Charges associated with excluded coverage under the Medical Plan,
- (2) Most drugs that can be purchased without a written prescription,
- (3) Most medical devices or supplies,
- (4) Any drug that is experimental, investigatory or is currently undergoing clinical trials for the prescribed use,
- (5) Most drugs consumed or administered, either in whole or in part, at the location where it is provided,
- (6) Some drugs associated with smoking prevention or cessation,
- (7) Any drug for uses associated with male or female sexual dysfunction, is limited to a maximum of six unit doses per month,
- (8) Any drug where the prescribed dosage exceeds the manufacturer's suggested dosage without an approved coverage exception,
- (9) Any drug that is subject to prior approval by the Pharmacy Benefit Manager for which prior approval was not obtained,
- (10) Some charges for allergens or the administration of allergens,
- (11) The administration of most drugs,
- (12) The charge for any drug covered under Worker's Compensation benefits,
- (13) Therapeutic devices or appliances,
- (14) Drugs designed for hair growth or cosmetic purposes,

DENTAL BENEFITS

Effective January 1, 2017, Cigna is the Dental Claims Administrator. Eligible members have access to the PPO II network. The benefits are the same when provided by an in-network or out-of-network dentist. Participating dentists bill at a prenegotiated fee and guarantee no balance billing other than plan deductibles and coinsurance.

Calendar Year deductible, per person \$50

The deductible applies to these Classes of Service:

Class A Services - Preventive

Class B Services - Basic

Class C Services - Major

Dental Percentage Payable

Class A Services-Preventive 100% by plan

Class B Services-Basic 80% by plan

Class C Services-Major..... 50%

Maximum Benefit Amount

Per person per Calendar Year \$2,500

► Dental Benefits

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

► Deductible Amount

This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

► Benefit Payment

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

► Maximum Benefit Amount

The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

► Dental Charges

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

► Covered Dental Services

Class A Services: Preventive and Diagnostic Dental Procedures

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two exams every Calendar Year per Covered Person.
- (2) Two bitewing x-ray series every Calendar Year.
- (3) One full mouth x-ray every three Calendar Years.
- (4) Emergency palliative treatment for pain.

Class B Services: Basic Dental Procedures

- (1) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (2) Periodontics (gum treatments).
- (3) Endodontics (root canals).
- (4) Extractions. This service includes local anesthesia and routine post-operative care.
- (5) Amalgam and white composite fillings.
- (6) General anesthetics, upon demonstration of Medical Necessity.
- (7) Antibiotic drugs.

Class C Services: Major Dental Procedures

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of synthetic porcelain materials will be included only when the teeth must be restored with gold,
- (2) Installation of crowns,
- (3) Installing precision attachments for removable dentures,
- (4) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during a six-month period following the installation,
- (5) Addition of clasp or rest to existing partial removable dentures,
- (6) Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits,
- (7) Repair or recementing of crowns, bridgework and removable dentures,
- (8) Rebasing or relining of removable dentures,
- (9) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits,
 - (b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable,
 - (c) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

► **Predetermination of Services**

Before starting a dental treatment for which the charge is expected to be \$750 or more, a predetermination of benefits form should be submitted.

A regular dental claim form is used for the predetermination of benefits. The Covered Person fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form. The Dentist should send the form to the Claims Processor.

All dental claims must be submitted within one year of the date of service to be eligible for reimbursement.

Dental claims will be processed by Cigna's claims processing center at the following:

Cigna
PO Box 188037
Chattanooga, TN 37422-8037
(800) 244-6224

The Claims Processor will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

► **Alternate Treatment**

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a composite, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

► **Exclusions**

A charge for the following is not covered:

- (1) Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting,
- (2) Services that are excluded under Medical Plan Exclusions,
- (3) Oral hygiene, plaque control programs or dietary instructions,
- (4) Implants, including any appliances and/or crowns and the surgical insertion or removal of implants,
- (5) Services which are not included in the list of covered dental services,

- (6) Orthodontic treatment and orthognathic surgery,
- (7) Personalization of dentures,
- (8) Replacement of lost or stolen appliances,
- (9) Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic,
- (10) All diagnostic and treatment services related to the treatment of jaw joint problems, including temporomandibular joint (TMJ) syndrome,
- (11) Fluoride treatment.

Cigna Discount Programs will be offered to all members enrolled in our Cigna dental plan. Discounts include certain gym memberships, weight loss programs, hearing devices, massage and acupuncture, LASIK surgery, Chiropractic visits, vitamins, herbal and nutritional supplements and natural products. However, discount programs are not available to members living in California. To learn more about these discount programs you can call Cigna member services toll-free at 1-800-244-6224.

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:

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 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 lenses ordered without a prescription.
- (5) Charges for orthoptics (eye muscle exercises).
- (6) Charges for safety goggles or sunglasses, 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.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (RNs) and does not provide for overnight stays.

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.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

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.

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/nonexperimental 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.

Generic drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

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.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (RN); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an agency whose main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

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.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one

registered nurse (RN) in continuous and constant attendance 24 hours a day.

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 require 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 Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. See your prescription drug plan's Evidence of Coverage for more information about a medically accepted indication.

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 appropriate 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.

Mental Disorder means any disease or condition that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables for a person of the same height, age and mobility as the Eligible Member.

Network Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices. A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with this plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

No Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

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, mental retardates, 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.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

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 coverage under this plan, please refer to the other plan materials you will receive from the Pharmacy Benefits Manager, Express Scripts.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (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 design 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.
- (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) Any loss that is due to a declared or undeclared act of war.
- (12) Any loss due to an intentionally self-inflicted Injury, while sane or insane.
- (13) All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (14) 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.
- (15) Care and treatment provided for cosmetic reasons. This exclusion will not apply if the care and treatment is for repair of damage from an accident that occurred while the person was covered under the Plan.
Reconstructive mammoplasty will be covered after Medically Necessary surgery, providing the reconstruction is performed within five years of the mastectomy and providing the Eligible Member was covered under the Plan at the time of the mastectomy.

- (16) 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.
- (17) Hearing aids and exams for their fitting. Coverage provided under the Hearing benefits are considered eligible when incurred while covered.
- (18) 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.
- (19) Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (20) 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.
- (21) Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Eligible Member's physical condition to make the original device no longer functional.
- (22) Services for educational or vocational testing or training.
- (23) 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.
- (24) 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.
- (25) Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.
- (26) Care, services or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (27) Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (28) Care and treatment for sleep disorders unless deemed Medically Necessary.
- (29) Exercise programs for treatment of any condition.
- (30) Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby. A hobby is hazardous if it is an unusual activity, which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies are skydiving, auto racing, hang gliding, jet ski operating or

bungee jumping.

- (31) Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (32) Care, services or treatment required as a result of complications from a treatment not covered under the Plan.
- (33) Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (34) Care or treatment for Injury or Sickness resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician.
- (35) Services, supplies, care or treatment of an Injury or Sickness which occurred as a result of an Eligible Member's negligent or illegal use of alcohol.
- (36) 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.
- (37) Care, service, supplies or drugs for which prior approval was required but was not obtained.
- (38) Chiropractic Modalities not covered by Medicare.
- (39) Insulin and Syringes (These items are covered by the Prescription Drug Benefit Plan).

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.

Effective January 1, 2017 dental claims will be filed with Cigna. Dental claims for services performed before January 1, 2017 should be filed with Aetna.

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 bill us 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.

Dental and drug claims must be submitted within one year of the date of service or receipt of the drug.

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. This Plan always pays secondary to Medicare.

Coverage provided through active employment pays first. Medicare pays primary for coverage as 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.

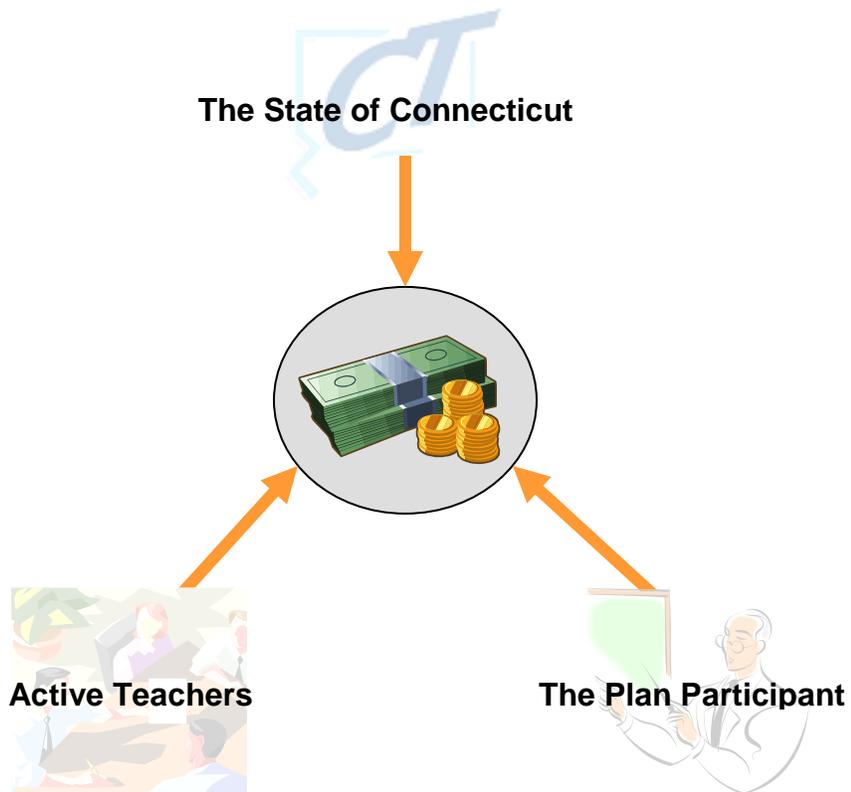
"Subrogation" means the Plan's right to pursue the Eligible Member's claims for medical charges against the other person.

"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.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded by:



Benefits are paid directly from the Plan through the Claims Administrator.

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: July 1, 1994, as amended. This description is effective January 1, 2017.

PLAN YEAR ENDS: December 31st.

MEDICAL CLAIMS ADMINISTRATOR

Stirling Benefits, Inc.
20 Armory Lane
Milford, CT 06460-3361
(800) 447-6689
www.stirlingbenefits.com

PRESCRIPTION DRUG SERVICES

Express Scripts
ATTN: MED D CLAIMS
PO Box 2858
Clinton, IA 52733-2858
(844) 433-4883
www.express-scripts.com

DENTAL CLAIMS ADMINISTRATOR

Cigna
PO Box 188037
Chattanooga, TN 37422-8037
(800) 244-6224
<http://www.cigna.com> or mycigna.com

PLAN SPONSOR INFORMATION

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