

# Connecticut State Teachers' Medicare Supplement Plan

Administered by Stirling Benefits, Inc.

## OUTLINE OF BENEFITS - 2017

Services	Benefit	Medicare Pays	This Plan Pays	You Pay
<b>Hospitalization</b> Semiprivate room and board, general nursing and other hospital services and supplies.	First 60 days	All but Medicare Part A Deductible \$1,316.00	Medicare Part A Deductible \$1,316.00	Nothing
	61 <sup>st</sup> to 90 <sup>th</sup> day	All but daily co-insurance \$329.00	Daily co-insurance \$329.00.	Nothing
	91 <sup>st</sup> to 150 <sup>th</sup> day	All but daily co-insurance \$658.00.	Daily co-insurance \$658.00	Nothing
	Beyond 150 days Up to an additional 60 days	Nothing	Up to an additional 60 days Prior authorization required	Nothing
<b>Medical Expenses</b> Physician services, inpatient and outpatient surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment.	Unlimited services if medically necessary.	After a \$183 Medicare Part B calendar year deductible, then Medicare pays 80% of the allowed amount.  Most providers accept assignment of benefits	If provider accepts assignment, this plan pays the remaining 20% of the allowed amount, covering the claim in full.  For non-assigned claims, the plan covers the assigned amount described above <u>plus</u> 80% of any additional billing.	The \$183.00 Medicare Part B deductible.  All other charges are paid in full if your provider accepts the Medicare assignment of benefits. If the provider does not accept assignment, the members share is approximately 3% of the total charge.
<b>Laboratory Services</b> Blood tests, urinalysis and other diagnostic services.	Unlimited, if medically necessary.	Generally 100% of the approved amount.	Nothing	Nothing
<b>Home Health Aide</b>	Services are medically necessary, limited to 4 hours per day.	Nothing	\$500.00 per calendar year	Any additional charges

### Out of Country

In-Patient Hospital Facility Charge – 30 days paid at 100% (physician's charges related to in-patient hospital stay is paid at 80%)

Out- Patient Charges for Life Threatening illness/accidents are paid at 80%. All other medical treatments are paid at 20%.

Prescriptions and lab charges are not covered. Payment is limited to a Lifetime maximum of \$100,000.00



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Services	Benefit	Medicare Pays	This Plan Pays	You Pay
<b>Outpatient Hospital and Ambulatory Surgical Services</b> Services for the diagnosis or treatment of an illness or injury.	Unlimited, if medically necessary.	Medicare payment to the hospital, based on hospital costs.	20% that Medicare does not pay the hospital.	Nothing
<b>Blood</b>	Unlimited during a benefit period	80% of approved amount (deductible applies and starting with the 4 <sup>th</sup> unit).	First 3 units of blood at 100%.	Nothing
<b>Skilled Nursing Facility Care</b> Semiprivate room and board; skilled nursing and rehabilitative services and other services and supplies (neither Medicare nor the TRB plan will pay for long term nursing home care).	First 20 days:	100% of the approved amount.	Nothing	Nothing
	Additional 80 days:	All but \$164.50.00 daily Co-insurance.	Daily co-insurance \$164.50.00 a day	Nothing
	Beyond 100 days, up to an additional 20 days: requires case management	Nothing	Up to an additional 20 days Prior authorization required	Nothing
<b>Hospice Care</b> Pain relief, symptom management, and support services.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Nothing	Nothing
<b>Prescription Drugs</b>  <b>\$400.00 deductible combined for retail/mail-order scripts.</b>  <b>Member pays Coinsurance amount plus annual deductible until annual out of pocket maximum is met; then plan pays 100% for the remainder of the year.</b>	Covered drugs that are available with a physician's prescription.	Nothing	<b>Retail service</b> <ul style="list-style-type: none"> <li>• Generic drugs 100%</li> <li>• Preferred drugs 80%</li> <li>• Non-Preferred drugs 70%.</li> </ul>	<b>\$400 deductible combined for retail/mail-order scripts.</b>  <b>Member pays Coinsurance amount plus annual deductible until annual out of pocket maximum is met; then plan pays 100% for the remainder of the year.</b>
			<b>Mail order drugs</b> <ul style="list-style-type: none"> <li>• Generic drugs, 100%</li> <li>• Preferred drugs 80%</li> <li>• Non-preferred drugs 70%</li> </ul>	

### Vision Benefit

Eye exam in a 12 month period (includes refraction)      \$75.00  
 Frames-1 pair in a 24 month period                              \$100.00  
 Contact Lenses per calendar year                                \$120.00

Frame type lenses in a 24-month period:

Single Vision	\$60.00	Trifocal	\$120.00	Progressive lenses	\$120.00
Bifocal	\$80.00	Lenticular	\$200.00		

**(Medicare pays for 1 pair of eyeglasses after cataract surgery) Sunlasses are not covered**

### Hearing Benefit

Hearing Aids      \$750.00 allowance every 36 months  
 (includes fittings and adjustment)

