

Connecticut State Teachers' Medicare Supplement Plan
Administered by Stirling Benefits, Inc.

OUTLINE OF BENEFITS - 2018

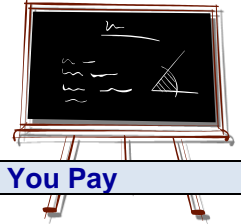
Services	Benefit	Medicare Pays	This Plan Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and other hospital services and supplies.	First 60 days	All but Medicare Part A Deductible \$1,340.00	Medicare Part A Deductible \$1,340.00	Nothing
	61 st to 90 th day	All but daily co-insurance \$335.00	Daily co-insurance \$335.00.	Nothing
	Plus an additional 60 lifetime reserve days	All but daily co-insurance \$670.00.	Daily co-insurance \$670.00	Nothing
	After Medicare benefits are exhausted: an additional 60 days per calendar year	Nothing	Up to an additional 60 days per calendar year Prior authorization required	Nothing
Medical Expenses 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. Almost all 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 when your provider accepts the Medicare assignment of benefits.
Laboratory Services Blood tests, urinalysis and other diagnostic services.	Unlimited, if medically necessary.	Generally 100% of the approved amount.	Nothing	Nothing
Home Health Aide	Services that are medically necessary, limited to 4 hours per day.	Nothing	Up to \$500.00 per calendar year	Any additional charges

Out of Country

In-Patient Hospital Facility Charge – 30 days paid at 100%. Physician charges related to in-patient hospital stay are paid at 80%. Out- Patient charges for emergency/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. Third party billing is not accepted. Facility charge must be paid at time of discharge.



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Services	Benefit	Medicare Pays	This Plan Pays	You Pay
Outpatient Hospital and Ambulatory Surgical Services	Unlimited, if medically necessary.	Medicare payment to the hospital, based on hospital costs.	20% that Medicare does not pay the hospital.	Nothing
Skilled Nursing Facility Care Semiprivate room and board; skilled nursing and rehabilitative services and other services and supplies	First 20 days:	100% of the approved amount.	Nothing	Nothing
	Additional 80 days:	All but \$167.50 daily Co-insurance.	Daily co-insurance \$167.50 a day	Nothing
	Extra 20 days Prior authorization required	Nothing	100% of the cost for an additional 20 days	Nothing
Hospice Care 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
Prescription Drugs \$405.00 deductible combined for retail/mail-order scripts. Member pays Coinsurance amount plus annual deductible until annual out of pocket maximum is met; then plan pays 100% of RX costs for the remainder of the year.	Covered drugs that are available on the Express Scripts formulary.	Nothing	Retail service <ul style="list-style-type: none"> • Generic drugs 95% • Preferred drugs 80% • Non-Preferred drugs 70%. 	\$405 deductible combined for retail & mail-order scripts. Member pays Coinsurance amount plus annual deductible until annual out of pocket maximum is met; then plan pays 100% of RX costs for the remainder of the year.
			Mail order drugs <ul style="list-style-type: none"> • Generic drugs, 95% • Preferred drugs 80% • Non-preferred drugs 70% 	

Vision Benefit

Eye exam - in a 12 month period (includes refraction) \$75.00

Frames - one frame in a 24 month period \$100.00

Lenses - one set of frame type lenses in a 24-month period as follows:

Single vision - \$60.00, bifocal - \$80.00, trifocal and progressive lenses - \$120.00, Lenticular – up to \$200.00.

Or, do not purchase glasses and instead reimburse for contact lenses up to \$120.00 per calendar year.

Sunglasses are not covered. Medicare pays for 1 pair of eyeglasses after cataract surgery.

Hearing Benefit

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