



STATE OF CONNECTICUT  
TEACHERS' RETIREMENT BOARD  
765 ASYLUM AVENUE HARTFORD, CT 06105-2822  
Toll free 1-800-504-1102 (860) 241-8400 Fax (860) 622-2849  
"An Affirmative Action/Equal Opportunity Employer", [www.ct.gov/trb](http://www.ct.gov/trb)

October 2010

## PREMIUM INCREASE NOTIFICATION AND TRB HEALTH PLAN CHANGE FORM EFFECTIVE JANUARY 1, 2011

### Premium Increase Notification

<u>Coverage Type</u>	<u>Monthly, Per Person</u>
Medicare Supplement with Prescriptions*	\$125.00
Medicare Supplement with Prescriptions & Dental	\$174.00
Medicare Supplement with Prescriptions, Dental, Vision & Hearing	\$179.00

\*This plan has been designated as the base plan available through the Teachers' Retirement Board. The full premium for the base plan is \$375 monthly per person, in 2011. Two-thirds of the premium for this base plan is subsidized on your behalf (\$250). The plan participant pays one-third of the premium (\$125).

**Change in Coverage Form:** This is your annual opportunity to add or drop your level of coverage through the Teachers' Retirement Board. If you are going to make a change, you must submit the appropriate change form on or before November 15, 2010. If you are not making a change, you do not have to submit the enclosed form. On January 1, 2011 you are locked into your plan through the end of the year. The 2011 premiums apply to all plan participants. No one is grandfathered into a prior year premium.

**DIABETIC SUPPLIES (Test Strips, Lancets, and Monitors)** are available through a retail pharmacy or thru 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 purchase prescriptions at a pharmacy we recommend that you shop around.
- To expedite mail order prescriptions, have your physician fax the order directly to Caremark, as it is Caremark's practice to fill orders upon receipt of the request from your physician. Allow up to four weeks for processing should you decide to fax or mail the prescription order form in yourself. If your physician changes your prescription, submit and get confirmation from Caremark that the original prescription will be cancelled.
- 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 advance program or the prescription program of another employer who also receives the federal reimbursement. To find out if another prescription program receives the federal reimbursement you must contact the benefits department of the other employer.
- Your address is submitted to the health plan vendors on the 1<sup>st</sup> work day of each month. You must submit address changes in writing, including your signature, directly to us at the above address.

The Delta Dental Group ID number is 45780003. Your temporary personal Delta I.D. number is your social security. Do not write your social security number on your temporary card. Delta will be issuing new member I.D. cards to everyone with a unique identification number on it. Look for your new dental card in the mail over the next several weeks if you are an existing or new Delta dental plan member through the Teachers' Retirement Board.



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**HEALTH INSURANCE CHANGE FORM  
 RETIREE**

This form is to be used by a retiree who is currently enrolled in the Teachers' Retirement Board Health Plan (referred to as Stirling coverage) 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.
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- One application is required by November 15, 2010, from each person making a change
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- Your change will become effective January 1, 2011.

	Cost per person per month	Check one(x)
Medicare Supplement with Prescriptions	\$125.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental	\$174.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	\$179.00	<input type="checkbox"/>
If you have health insurance in addition to Medicare A & B and Stirling, please check this box	<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	
Last Four digits of SSN  <b>XXX-XX-</b>	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.**

Be sure to include a copy of your Medicare Card if you are making a change to your coverage.

One application is required by November 15, 2010, from each person making a change to his or her coverage

Your change will become effective January 1, 2011.

	Cost per person per month	Check one(x)
Medicare Supplement with Prescriptions	\$125.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental	\$174.00	<input type="checkbox"/>
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	\$179.00	<input type="checkbox"/>
If you have health insurance in addition to Medicare A & B and Stirling, please check this box.	<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		
Last Four Digits of SSN  <b>XXX-XX-</b>		Medicare Number		Date of Birth	
Enrollee's Signature				Date	

Also please furnish the following:

Retired Teacher's Name	Last Four Digits of Retired Teacher's SSN  <b>XXX-XX-</b>	Retiree's Signature
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