



Connecticut State Teachers' Medicare Supplement Plan Administered by Stirling Benefits

OUTLINE OF BENEFITS 2011

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 \$1,132.00	Medicare Part A Deductible \$1,132.00	Nothing
	61 st to 90 th day	All but daily co-insurance \$283.	Daily co-insurance \$283.	Nothing
	91 st to 150 th day	All but daily co-insurance \$566.	Daily co-insurance \$566.	Nothing
	Beyond 150 days Up to an additional 60 days	Nothing	Up to an additional 60 days 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.	80% of the approved amount (after Medicare Part B \$162.00 per calendar year deductible); or 50% of approved amount for most outpatient mental health services. Most providers accept assignment	If provider accepts assignment: 20% (or 50%) that Medicare does not pay; For non-assigned claims, the plan covers the assigned amount described above <u>plus</u> 80% of any additional billing.	The \$162. Medicare Part B deductible. All other charges are paid in full if your provider accepts Medicare assignment of benefits . If the provider does not accept assignment, the members share is approximately 3% of the total charge.
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 are medically necessary, limited to 4 hours per day.	Nothing	\$500.00 per calendar year	Any additional charges

Out of Country

In-Pat Hospital Facility Charge – 30 days paid at 100% (physician's charges paid at 80%)

Out Patient charges for Emergency illness/accident paid at 80% no deductible.

Out-Patient Non Emergency is limited to equivalent services covered by Medicare while in the USA-Plan pays 20%.

Payment is limited to a Lifetime maximum of \$100,000.00.



Connecticut State Teachers' Medicare Supplement Plan

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Outpatient Hospital and Ambulatory Surgical Services 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
Blood	Unlimited during a benefit period, if medically necessary.	80% of approved amount (deductible applies and starting with the 4 th pint).	First 3 pints of blood at 100%.	Nothing
Skilled Nursing Facility Care Semiprivate room and board; skilled nursing and rehabilitative services and other services and supplies (neither Medicare, HMO's 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 daily-co-insurance.	Daily co-insurance \$141.50 a day	Nothing
	Beyond 100 days, up to an additional 20 days:	Nothing	Up to an additional 20 days Prior authorization required	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 \$250.00 deductible combined for retail/mail order scripts. Maximum annual out of pocket cost is \$1,000 per calendar year including the deductible.	All drugs are available with a physician's prescription.	Nothing	Retail service Generic drugs; 95% for the first two scripts, then 90% Preferred drugs 80% Non-Preferred drugs 70%.	\$250.00 deductible combined for mail order/retail scripts. Generic drugs 5% or 10% Preferred drugs 20% Non-preferred drugs 30%
			Mail order drugs Generic drugs 95% Preferred drugs 80% Non-preferred drugs 70%	

Vision Benefit

Eye exam in a 12 month period (not approved by Medicare) \$75.00
 Frames, per pair, in a 24 month period \$100.00

Frame type lenses or contact lenses, in a 24-month period:

Single Vision	\$60.00	Lenticular	\$200.00
Bifocal	\$80.00	Contact Lenses	\$240.00

Trifocal \$120.00

Lenticular \$200.00

Sunglasses are not covered.

(Medicare pays for 1 pair of eyeglasses after cataract surgery)

Hearing Benefit

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

