

2019 Connecticut State Teachers' Medicare Supplement Plan

Covered Services	Medicare benefit	Medicare Pays	TRB Pays	You pay
<p>Hospital Services (Part A hospital services)</p> <p>Including hospital room and board nursing services, hospital services and supplies</p>	<p>First 90 days of any hospitalization. The 90 day benefit resets and repeats for a new hospital stay</p> <p>An additional 60 lifetime days if the first 90 days used during any one stay</p> <p>Plus an additional 60 days per calendar year if the above benefits are used.</p>	<p>The vast majority of all hospital expenses</p>	<p>All covered patient out-of-pocket expenses once Medicare has paid, except a \$250 copayment per hospital stay, up to a maximum of four copayments per calendar year.</p>	<p>\$250 Copayment per admission, up to maximum of four copayments per year.</p>
<p>Medical Services Part B Outpatient Services</p> <p>Surgical services, lab work, diagnostic tests, therapeutic services (physical, occupational, speech therapy), diabetic and DME supplies Including but not limited to radiation therapy, X-ray PET, CT, SPECT, MRI scans</p>	<p>Medically necessary covered services</p>	<p>After the Part B calendar year deductible, Medicare then pays 80% of the allowed amount</p>	<p>After \$185 Medicare Part B deductible Currently \$185, \$500 TRB Plan deductible, 10% cost share up to a maximum patient out-of-pocket limit of \$1,185 for the calendar year.</p> <p>After the \$1,185 Part B maximum out of pocket limit has been reached, the TRB plan pays 100% of any patient Part B approved Medicare charges.</p> <p>The TRB plan pays 100% of any additional "unassigned charges"</p>	<p>Members are responsible for:</p> <p>a) the \$185 Medicare Part B deductible, b) a \$500 TRB plan deductible, then c) 10% of the patient liability after Medicare has paid their share</p> <p>To a Part B maximum of \$1,185</p>

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Outpatient Hospital Use of surgical center, administration of part B drugs tests billed by the facility etc.	Medically necessary covered services	Depending upon service covered as a Part B service. Some services covered in full or subject to other cost shares	Same as Medicare Part B services	Same as Medicare Part B services
Hospice services	Medically necessary covered services	Generally covered in full	N/A	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 \$170.50 daily coinsurance	Daily coinsurance \$170.50 per day	Nothing
	Extra 20 days – prior authorization required	Nothing	100% of the cost of up to an additional 20 days	Nothing

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.

Part D prescription drugs are covered under the Express Scripts Program.

Vision and Hearing Program

Vision Benefit

Exam including refraction \$75 allowance every 12 months; Frames up to \$100 every 24 months
 Lenses every 24 months 1 set. Allowances for lenses are Single \$60, Bifocal \$80, Trifocal & Progressive \$120, Lenticular \$200
 In lieu of glasses member may opt for \$120 contact lenses allowance per calendar year. No coverage for sunglasses. This benefit is in excess of any Medicare glass coverage.

Hearing Benefit

\$750 allowance every 36 months includes services.