CT TEACHERS' RETIREMENT BOARD
765 ASYLUM AVENUE HARTFORD, CT 06105-2822
Toll Free 1-800-504-1102 X8411 or X8432 (860) 241-8411 or 860-241-8432 Fax (860) 622-2849
"An Affirmative Action/Equal Opportunity Employer"
www.ct.gov/trb

HEALTH INSURANCE APPLICATION

Mandatory Eligibility Requirements

- Participation in Medicare Part A and Medicare Part B
- A member collecting a retirement benefit or a disability allowance, or
- A spouse of a retired member, or
- A surviving spouse who has not entered into another marriage, or
- A disabled dependent of a member collecting a retirement benefit or a disability allowance, if there is no spouse or surviving spouse.
- You must be a legal resident of the United States to participate in the TRB health plan.

Mandatory Filing Requirements

- Proof of participation in Medicare Part A and Medicare Part B (a copy of Medicare Card or a letter from Social Security providing the Medicare I.D. Number and the effective dates for Medicare Part A and Medicare Part B)
- Copy of a marriage certificate or a marriage license from spouse, if enrolling
- If the application includes coverage for a disabled dependent, a copy of the member's most recent federal income tax return documenting the disabled dependent's status as the member's dependent
- One form per enrollee must be received by the 25th of the 2nd month preceding the effective date of coverage. We will send an acknowledgement letter within two weeks of our receipt of your application. If you do not receive an acknowledgement letter, please call us.

Cancelling Your TRB Coverage

- You may cancel all coverage at any time; however you will not be able to reenroll for two years.

Important Information Regarding Our Plan

- Our health care coverage is offered as a single package which includes Hospital, Medical, Major Medical, Prescription Drug Benefits and Dental, Vision & Hearing. The cost of the package in 2017 is $141 per month per person.
- The federal government will only subsidize one prescription plan for you at a time. Inasmuch as the TRB plan receives federal funding you are not allowed to participate in another Medicare D prescription program, a Medicare advantage program, or the prescription program of another plan sponsor who receives the federal reimbursement while enrolled in the TRB plan. If we are notified that you are participating in one of these plans, your TRB health coverage will be cancelled, including your Medicare supplemental health plans or any other coverage you may have with us.
- The cost of prescription drugs varies from one pharmacy to another, therefore, if you use a retail pharmacy we encourage you to shop around.
- The annual prescription deductible of $400 begins on January 1st and is not prorated when you participate for a portion of the year. Members enrolling late in the year are subject to the full $400 deductible in the year they enroll and are also subject to the full $400 deductible in the new year which begins the following January. For example, if joining the plan on December 1st, there is a deductible that would apply for December that would be renewed for January 1st, since these two months fall in different calendar years.

- Some members may be required to pay an extra amount for Part D because of their yearly income. This is known as the Part D Income-Related Monthly Adjustment Amount or Part D-IRMAA and it is paid directly to the federal government not to the TRB. For more information on Part D-IRMAA you can visit the Medicare website: http://www.medicare.gov or call Medicare at 800-633-4227.
- **Effective January 1, 2017**, Cigna will be your new Dental Claims Administrator. You will be mailed a welcome package which will include a toll-free telephone number and important information before the end of November. Cigna ID cards will be mailed separately also before the end of November. The maximum per member annual dental limit is $2,500.
- A spouse is not eligible for TRB coverage upon divorce or legal separation. In the event a former spouse is participating in the TRB sponsored health insurance plan, the member must inform TRB and provide a copy of the legal separation or dissolution of marriage as soon as possible.
- A surviving spouse is not eligible upon remarriage. Prompt notification is required.
- The TRB provides address changes to all of our health plan vendors. You must maintain your current address with us at all times to ensure as little disruption as possible in the delivery of services and the processing of claims.
- Post Retirement Reemployment (PRR) - If a member is reemployed as a public school teacher following their retirement, the member (and spouse or dependent) can elect to continue their TRB health plan coverage while reemployed, but at full cost, currently $325 per person per month.

The Health & Prescription Drug Benefits Plan Summary is available on our website at: http://www.ct.gov/trb/lib/trb/formsandpubs/SPD-WEB.pdf .

MEDICAL CLAIMS ADMINISTRATOR

Stirling Benefits, Inc.
20 Armory Lane
Milford, CT 06460-3361
(800) 447-6689 http://www.stirlingbenefits.com/

PRESCRIPTION DRUG SERVICES

Express Scripts
One Express Way
St. Louis, MO 63121
(844) 433-4883 www.express-scripts.com

DENTAL CLAIMS ADMINISTRATOR

Cigna Dental
PO Box 188037
Chattanooga, TN 37422-8037
(800) 244-6224 http://www.cigna.com or mycigna.com

PLAN SPONSOR INFORMATION

Connecticut Teachers' Retirement Board
765 Asylum Avenue
Hartford, CT 06105-2822
Direct-Dial (860) 241-8411
Toll-Free (800) 504-1102 http://www.ct.gov/trb

Retain This Important Document for Future Reference

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Member
Health Insurance Application

- A photocopy of your Medicare Card, or a letter from Social Security providing your Medicare membership number and effective date of your coverage under Medicare Part A and Medicare Part B, must be submitted with this application.
- We must receive your application by the 25th of the 2nd month preceding the effective date of coverage. (e.g., by February 25th for coverage to be effective April 1st)
- You may cancel all coverage at any time; reenrollment will be subject to all plan coverage, including dental, vision and hearing.
- The annual prescription deductible is on a calendar year basis, from January to December. Members enrolling during the year are subject to the full $400 deductible for the year in which they enroll; a new deductible would begin the following January.
- Premiums are deducted monthly from your retirement benefit.

	Cost per person per month	**Effective Date**
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$141.00	

Enrollee's Last Name, First Name, Initial	Home Phone	Gender: Male ☐ Female ☐
Street Address	City	State / Zip Code
Social Security Number	Date of Birth	Email Address
Enrollee's Signature	Date	

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Spouse, Surviving Spouse or Disabled Dependent
Health Insurance Application

- A photocopy of your Medicare Card, or a letter from Social Security providing your Medicare membership number and effective date of your coverage under Medicare Part A and Medicare Part B, must be submitted with this application.
- A photocopy of a marriage license or a marriage certificate.
- A spouse becomes ineligible upon legal separation or divorce.
- A surviving spouse becomes ineligible upon remarriage.
- If the application includes coverage for a disabled dependent, a copy of the member's most recent federal income tax return documenting the disabled dependent's status as the member's dependent is required.
- We must receive your application by the 25th of the 2nd month preceding the effective date of coverage. (e.g., by February 25th for coverage to be effective April 1st)
- You may cancel all coverage at any time; reenrollment will be subject to all plan coverage, including dental, vision and hearing.
- The annual prescription deductible is on a calendar year basis, from January to December. Members enrolling during the year are subject to the full $400 deductible for the year in which they enroll; a new deductible would begin the following January.

	Cost per person per month	**Effective Date**
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$141.00	

Enrollee's Last Name, First Name, Initial	Home Phone	Gender: Male ☐ Female ☐
Street Address	City	State / Zip Code
Social Security Number	Date of Birth	Email Address
Enrollee's Signature	Date	

If you are enrolling as the spouse or the disabled dependent of a retired teacher, please have the retiree sign below:

Retired Teacher's Name	Retired Teacher's Social Security #	Retired Teacher's Signature