

Plan for Retirees of: CT State Teachers' Retirement Board

Underwritten by: Hartford Life and Accident Insurance Company

Calendar Year Deductible: Medicare Part B deductible amount

Calendar Year Out-of-Pocket Maximum: \$2,000 (excludes Part B deductible)

Part A Services

Services	Medicare pays ¹	Plan pays ¹	You pay
Hospitalization²			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but the Part A deductible	After covered person's copay of \$250, plan pays 100% of Medicare Part A deductible	\$250 copay per admission
61 st through 90 th day	All but 25% of the Part A deductible	100% of Medicare Part A coinsurance	\$0
91 st through 150 th day (60-day lifetime reserve period)	All but 50% of the Part A deductible	100% of Medicare Part A coinsurance	\$0
Once lifetime reserve days are used (or would have ended if used), additional 365 days of confinement per person per lifetime.	\$0	100%	\$0
Skilled Nursing Facility Care			
Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but 12.5% of the Part A deductible per day	After covered person's copay of \$250, plan pays up to 100%	\$250 copay per admission
Blood Deductible – Hospital Confinement and Outpatient Medical Expenses			
When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints	\$0	100%	\$0
Additional amounts	100%	\$0	\$0

Part A Services (continued)

Services	Medicare pays ¹	Plan pays ¹	You pay
Hospice Care Pain relief, symptom management and support services for terminally ill.			
As long as physician certifies the need	All costs, but limited to costs for outpatient drug and inpatient respite care	Co-insurance charges for inpatient respite care, drugs and biologicals approved by Medicare	All other charges

Part B Services

Services	Medicare pays ¹	Plan pays ¹	You pay
Outpatient Medical Expenses All Medicare Part B benefits are based on per visit, except Ambulance Services Benefit, which is based on per trip and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.			
Medicare Part B deductible	\$0	\$0	100%
Physician Services Benefit	80%	After covered person's copay of \$10, plan pays 100% of the remaining Medicare Part B coinsurance	\$10 Copay
Specialist Services Benefit	80%	After covered person's copay of \$10, plan pays 100% of the remaining Medicare Part B coinsurance	\$10 Copay
Outpatient Hospital Services and Ambulatory Surgical Care Benefit	80%	100% of the remaining Medicare Part B coinsurance	\$0
Outpatient Diagnostic and Radiology Services Benefit	80%	100% of the remaining Medicare Part B coinsurance	\$0
Outpatient Mental Health and Substance Abuse Services Benefit	80%	After covered person's copay of \$10, plan pays 100% of the remaining Medicare Part B coinsurance	\$10 Copay
Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit	80%	100% of the remaining Medicare Part B coinsurance	\$0
Emergency Care Benefit	80%	100% of the remaining Medicare Part B coinsurance	\$0
Urgent Care Benefit	80%	100% of the remaining Medicare Part B coinsurance	\$0
Ambulance Services Benefit	80%	100% of the remaining Medicare Part B coinsurance	\$0
Durable Medical Equipment and Prosthetics Benefit	80%	100% of the remaining Medicare Part B coinsurance	\$0
Medicare covered Chiropractic and Acupuncture Services ⁴	80%	100% of the remaining Medicare Part B coinsurance	\$0

Part B Services (continued)

Services	Medicare pays ¹	Plan pays ¹	You pay
Part B excess charges for non-participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare-approved Part B charge.	\$0	100%	\$0

Additional Services

Services	Medicare pays ¹	Plan pays ¹	You pay
Preventive Medical Care and Cancer Screenings³ Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings and any other tests or preventive measures determined to be appropriate by the attending physician. Refer to your “Medicare and You” handbook for more information on preventive services.			
“Welcome to Medicare” physical exam within first 12 months of Part B	100%	\$0	\$0
Annual wellness visit	100%	\$0	\$0
Vaccinations	100%	\$0	\$0
Preventive Care Cancer Screening Benefits ³	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B deductible and coinsurance	100% of remaining covered expenses incurred not covered by Medicare	\$0
Foreign Travel Emergency Medically necessary emergency care services.			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	\$0	100% to a lifetime maximum of \$250,000	Any remaining charges after \$250,000 Lifetime Maximum
Chiropractic Services⁴			
Services performed by a licensed chiropractor to correct structural alignment.	0% of non-Medicare covered services	After covered person’s copay of \$20, plan plays 100% of remaining non-Medicare covered expenses incurred	\$20 copay per exam
Annual Physical Exam			
The exam may include a review of medical history and a discussion of risk factor reductions and other services performed as part of an annual exam which are not covered by Medicare or under another benefit in the policy.	After the “Welcome to Medicare Physical Exam” \$0	100% of remaining covered expenses incurred	\$0 copay per exam per calendar year

Additional Services (continued)

Services	Medicare pays ¹	Plan pays ¹	You pay
Acupuncture Services⁴			
Services performed by a licensed acupuncturist to treat pain.	0% of non-Medicare covered services	100% of remaining non-Medicare covered expenses incurred, after the copayment, up to the benefit maximum of \$500 ⁵ per calendar year	\$25 copay per exam and any charges in excess of \$500 per calendar year
Hearing Services			
One routine hearing and balance exam every 12 months Two hearing aids every two years One hearing aid fitting evaluation every two years	\$0	100% of covered expenses incurred, after the copayment, up to the benefit maximum of \$5,000 ⁵ per calendar year	\$0 copay per exam \$0 copay for two hearing aids, including fitting and evaluation and any charges in excess of \$5,000 per calendar year
Vision Services			
One supplemental routine eye exam every 12 months One pair of glasses every 12 months or 12-month supply of contact lenses	\$0	100% of covered expenses incurred, after the copayment, up to the benefit maximum of \$500 ⁵ per calendar year	\$0 copay per exam \$0 copay per pair of glasses or supply of contact lenses and any charges in excess of \$500 per calendar year



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Please note this policy also may cover certain benefits mandated by CT, the state where this policy is situated, or mandated by the state where you reside. Refer to your certificate for a description of any additional benefits.

NOT CONNECTED WITH OR ENDORSED BY THE U.S. GOVERNMENT OR THE FEDERAL MEDICARE PROGRAM.

Limitations & Exclusions: The Hartford's Insurance Plan does not cover any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in the policy. The plan does not cover: Any part of a covered expense to the extent paid by Medicare; benefits payable under one benefit of the policy to the extent covered under another benefit of the policy; or expense incurred after coverage terminates, except as stated in the Extension-of-Benefits provision of the policy.

Group Retiree Health Form Series includes GBD-2400, GBD-2500, or state equivalent.

Not available in all states.

¹ This chart describes coverage that is only available to persons who are Medicare-eligible. Medicare amounts typically change January 1 of each year.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Hospital does not include any institution or part thereof that is used primarily as a nursing home, convalescent home, or Skilled Nursing Facility; a place for rest, custodial, educational or rehabilitation care; a place for the aged; or, a place for alcoholism or drug addiction.

³ If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred. Please refer to your certificate for a full description of preventive screenings.

⁴ Medicare only covers chiropractic manual spinal manipulations to correct vertical subluxation and acupuncture for chronic low back pain under specific conditions. Medicare covered chiropractic and acupuncture services are covered under Part B.

⁵ Does not contribute to the out-of-pocket maximum.