2026 Summary of Benefits

CONNECTICUT TEACHERS RETIREMENT BOARD

Sponsored by Aetna Medicare Plan (PPO)
Medicare (P01) ESA PPO Plan

Keep in mind

This is just a summary. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage* (EOC). You can request a copy of the SOC/EOC by contacting:

Member Services
1-866-495-0761 (**TTY:** 711)
Hours are 8 AM to 9 PM ET, Monday through Friday.

This is a summary of the services we cover from January 1, 2026 through December 31, 2026.

Are you eligible to enroll?

To join Aetna Medicare Plan (PPO), you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan's service area

Service area: A complete list of service areas can be found in the *Evidence of Coverage* (EOC).

What You Should Know

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Plan costs & information	Network & Out-of-network providers
Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible	$0
	This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.
Annual Maximum Out-of-Pocket	$2,000
	The maximum out-of-pocket (MOOP) is the **most you'll pay** for the medical services we cover each year. **It's in place to protect you**. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium doesn't count toward your MOOP.

PRIMARY BENEFITS	Your costs for in and out-of-network care
Hospital Care*	
Inpatient Hospital Care	$200 per stay The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Observation Stay	$10
Frequency	per stay
Outpatient Hospital Services and Surgery	$10
Ambulatory Surgery Center	$10
Physician Services	
Primary Care Provider Visits	$10 Includes the services of an internist, general physician or family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.
Physician Specialist Visits	$10
Preventive Services	
Medicare-covered Preventive Services • Abdominal aortic aneurysm screenings • Alcohol misuse screenings and counseling • Annual Wellness visit • Bone mass measurements • Breast cancer screening: mammogram • Cardiovascular behavior therapy • Cardiovascular disease screenings • Cervical and vaginal cancer screenings • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screenings • Diabetes screenings • HIV screenings • Lung cancer screenings and counseling • Medicare Diabetes Prevention Program • Medical nutrition therapy • Obesity behavior therapy • Prostate cancer screenings (PSA)	$0

PRIMARY BENEFITS	Your costs for in and out-of-network care
Preventive Services (continued)	
• Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit	
Immunizations • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Diabetes self-management training • Digital rectal exam • EKG following welcome exam • Glaucoma screening	$0
Emergency and Urgent Medical Care	
Emergency Care	$100 (waived if admitted within 72 hours)
Emergency Care Worldwide	$100 (waived if admitted)
Urgent Care	$10 (waived if admitted within 72 hours)
Urgent Care Worldwide	$10
Diagnostic Procedures*	
Diagnostic Radiology (CT scans)	$0
Diagnostic Radiology (other than CT scans)	$0
Diagnostic Testing and Procedures	$0
Lab Services	$0
Outpatient X-rays	$0
Hearing Services	
Hearing Exam (routine)	$0
	Coverage: one exam every twelve months
Hearing Exam (Medicare-covered)	$10

PRIMARY BENEFITS	Your costs for in and out-of-network care
Hearing Aid Benefit	Our plan pays $1,500 once every 36 months.
Vendor	NationsHearing
Dental Services*	
Dental Services	$10
	Medicare-covered benefits only
Vision Services	
Eye Exam (routine)	$10
	Coverage: one exam every year
Diabetic Eye Exam	$0
Eye Exam (Medicare-covered)	$10
Eyewear Reimbursement	$500 once every 24 months
Mental Health Services*	
Inpatient Mental Health Care	$200 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Mental Health Care	$10 (individual sessions)
	$10 (group sessions)
Partial Hospitalization Services	$10
Intensive Outpatient Service	$10
Inpatient Substance Use Disorder	$200 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Substance Use Disorder	$10 (individual sessions)
	$10 (group sessions)
Skilled Nursing Services*	
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-100
	Limited to 100 days per Medicare benefit period. See the *Schedule of Cost Sharing* for details on the benefit periods.
Outpatient Rehabilitation Services	

PRIMARY BENEFITS	Your costs for in and out-of-network care
Occupational Therapy Rehabilitation Services	$10
Physical and Speech Therapy Rehabilitation Services	$10
Ambulance* and Transportation Services	
Ambulance Services	$100
	Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.
Transportation (non-emergency)	Covered
	Coverage: up to 24 one-way trips per year with 60 miles allowed per trip.
Medicare Part B Prescription Drugs*	
Medicare Part B Prescription Drugs	$10

***These benefits may require prior authorization.**

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in and out-of-network care
Acupuncture Services	$10
	Medicare-covered benefits only
Allergy Shots	$10
Allergy Testing	$10
Blood	$0
	All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	$10
Chiropractic Services*	$10
	Medicare-covered benefits only
Diabetic Supplies*	$0
	Includes supplies to monitor your blood glucose from Accu-Chek/Roche and TRUE/Trividia, or from a non-preferred provider when a prior authorization is received.
Durable Medical Equipment (DME)*	$0
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.
Intensive Cardiac Rehabilitation Services	$10
Medical Supplies*	$10
Outpatient Dialysis Treatments*	$10
Podiatry Services	$10
	Medicare-covered benefits only
Prosthetic Devices*	$0
Pulmonary Rehabilitation Services	$10
Supervised Exercise Therapy (SET) for PAD	$10
Radiation Therapy*	$0

***These benefits may require prior authorization.**

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in and out-of-network care
Compression Stockings	$10
Maximum	six pairs
Frequency	per plan year
Fitness Program	SilverSneakers®
Foot Orthotics	$10
Healthy Rewards	Covered
In-Home Support Services	$0
Coverage Type	UF Chronic Condition Post Discharge
Number of Hours	6 hours
Frequency	per discharge
Vendor	The Helper Bees
	You may be eligible to receive in-home support services after a qualifying discharge.
Meals	$0 After discharge from an inpatient stay to your home, you may be eligible to receive up to 28 home-delivered meals over a 14-day period.
Personal Emergency Response System	$0
	Our plan covers a medical alert response system from LifeStation to provide you with 24/7 access to help in the event of a fall or an emergency.
Podiatry Services (non-Medicare covered)	$10
	Supplemental podiatry services are covered for up to six visits every year per year.
Frequency	six visits every year
Resources for Living®	This program is offered to help you locate resources for everyday needs.
Routine Physical	$0
	A routine physical exam is offered once per calendar year.
Teladoc™	$0
	Telemedicine services with a Teladoc provider. State mandates may apply.
Telehealth PCP	$10

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in and out-of-network care
Telehealth Specialist	$10
Telehealth Occupational Therapy Service	$10
Telehealth PT and ST Services	$10
Telehealth Other Health Care Providers	$10
Telehealth Individual Mental Health*	$10
Telehealth Group Mental Health*	$10
Telehealth Individual Psychiatric Services*	$10
Telehealth Group Psychiatric Services*	$10
Telehealth Individual Outpatient Substance Use Disorder*	$10
Telehealth Group Outpatient Substance Use Disorder*	$10
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services*	$0
Telehealth Urgent Care	$10
Wigs	$0
Maximum	$400
Frequency	every year

***These benefits may require prior authorization.**

MEDICAL DISCLAIMERS

For more information about Aetna plans, go to **CTTRB.aetnamedicare.com** or call Member Services toll-free at **1-866-495-0761** (**TTY: 711**). Hours are 8 AM to 9 PM ET, Monday through Friday.

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the *Evidence of Coverage* (EOC). You can request a copy of the EOC by contacting Member Services at **1-866-495-0761** (**TTY: 711**). Hours are 8 AM to 9 PM ET, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your *Evidence of Coverage*.
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non-contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare-covered services under the plan.

PLAN DISCLAIMERS

Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

See *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call **1-800-MEDICARE** (TTY users should call **1-877-486-2048**), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (**www.medicare.gov**) or by calling 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

You can also visit our website at **AetnaRetireePlans.com**. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

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Notice of Availability (NOA)

TTY: 711

To access language services at no cost to you, call the number on this document. (English)

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للحصول على خدمات اللغة مجانًا، اتصل بالرقم المذكور في هذه الوثيقة. (Arabic)

如欲使用免費語言服務，請致電本文件上的電話號碼。 (Chinese)

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Inā ake ʻoe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ʻoe i ka helu ma kēia palapala. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj ntawm daim ntawv no. (Hmong)

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လၢကမၤန့ၢ် ကိုၣ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢာ်ဘူၣ်လၢာ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလံာ်တီလံာ်မီအံၤ အဖီခိၣ်နှၤ်တက့ၢ်. (Karen)

무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພ່ ອ ້ເຂົາເຖິງການ ບໍລິການພາສາໂດຍ ບເສຍຄ່ າໃ ້ຊ້ຈ່ າຍໃດໆ, ໃຫ້ ໂທຫາເ ບີໂທໃນເອກະສານ ີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبانی رایگان، با شماره مندرج در این سند تماس بگیرید. (Persian farsi)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany w tym dokumencie. (Polish)

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Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa dokumentong ito. (Tagalog)

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)

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