The Performance Plus Plan

Copayments At-A-Glance
Effective 01/01/2016

This Copayments-At-A-Glance section provides important copayment and coinsurance information for the most commonly utilized benefits. We encourage all participants to visit www.teachershealthtrust.org to review the Plan Document for detailed information. The complete 2016 Plan Document will be available to all participants in the coming weeks.

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Maximum Per Individual	$600 Per Year	$2,500 Per Year
Calendar Year Deductible Maximum	$600 per family member annually, not to exceed $1,800 per family	$2,500 per family member per year, not to exceed $10,000 per family
Calendar Year Total Out-of-Pocket Maximum Per Individual	$6,850 Per Individual	No Maximum for Out-of-Network Providers
Calendar Year Total Out-of-Pocket Maximum per Family	$13,700 Per Year	No Maximum for Out-of-Network Providers

PATIENT CENTERED MEDICAL HOME SERVICES

The Patient Centered Medical Home (PCMH) is a health care delivery model that provides primary health care that is coordinated and focuses on quality and safety while improving accessibility. It is not a physical place; it is the way your healthcare is accessed.

Your assigned/chosen PCMH provider will be a Primary Care Physician (PCP), Family Practice, Internal Medicine, or Pediatrician Provider. Women may also choose to have an OB/GYN as her second PCMH physician. Services provided within the PCMH by your PCMH Provider are defined only as approved office, consult, and preventive services. Services included in the 'Office Visit Co-Pay' include charges for the office visit or consult only. 20% co-insurance applies to all other services such as, but not limited to, urinalysis, pulse oximetry, administration of injections, medications, procedures, surgery, and testing.

	IN-NETWORK
Preventive Care	$0 Co-pay, Office Visit (deductible does not apply)
PCMH Provider	$10 Co-pay for Office Visit (deductible does not apply) 20% co-insurance for all other services (deductible does not apply)
Specialist Physician	$20 Co-pay for Office Visit with referral (deductible does not apply) 20% Co-insurance for all other services (deductible does not apply)
Medical Home Identified Chronic Condition Patients (Primary Care or Specialist Physician Office Visit - Diabetes, High-Risk Pregnancy, Cardiovascular, COPD and Asthma)	$0 Co-pay Office Visit (deductible does not apply) 20% co-insurance for all other services (deductible does not apply)
In-Office Surgery, without Anesthesiologist	20% co-insurance (deductible does not apply if at a Medical Home provider and in conjunction with a Medical Home Office Visit; otherwise, deductible applies)
Obstetrics (full pregnancy/delivery care bundle - Normal Pregnancy)	$10 copay for office visits, 20% co-insurance for all other services (deductible does not apply)
Obstetrics (full pregnancy/delivery care bundle - High Risk Pregnancy, pregnancies identified as High Risk by PCMH Provider and enrolled and compliant in that PCMH extension)	$0 copay for office visits, 20% co-insurance for all other services (deductible does not apply)

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME

	IN-NETWORK	OUT-OF-NETWORK
Preventive Care	Not Covered Outside the Medical Home	Not Covered for Out-of-Network Providers
Primary Care Physician	20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Specialist Physician	WITHOUT REFERRAL 20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME	IN-NETWORK	OUT-OF-NETWORK
Office Surgery	WITHOUT REFERRAL 20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Obstetrics (Full Pregnancy/Delivery Care Bundle - Normal Pregnancy)	20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Obstetrics (full pregnancy/delivery care bundle - High Risk Pregnancy, pregnancies identified as High Risk by PCMH Provider and enrolled and compliant in that PCMH extension)	20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Anesthesia	WITH OR WITHOUT REFERRAL 20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Facility (Includes Skilled Nursing & Mental Health/Chemical Dependency Facilities, Inpatient, Outpatient, Ambulatory Surgical Center, Long-Term Acute Care, or Acute Rehabilitation) **Daily flat rate does not apply to all other outpatient services, such as but not limited to; clinics, radiation, radiology services, chemotherapy, sleep studies, physical therapy.**	WITH OR WITHOUT REFERRAL $400 per day; $800 Max Per Stay (deductible does not apply) 20% co-insurance	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses* 20% co-insurance
Home Health/Hospice/Infusion	WITH OR WITHOUT REFERRAL 20% co-insurance (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Durable Medical Equipment - prosthetics & orthotics, including foot orthotics	WITH OR WITHOUT REFERRAL 20% co-insurance (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Ambulance	NO REFERRAL REQUIRED 20% co-insurance (deductible does not apply)	20% co-insurance (deductible does not apply)
Urgent Care	NO REFERRAL REQUIRED $50 co-pay (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Minute Clinics	NO REFERRAL REQUIRED $15 co-pay (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Emergency Room - True Emergency	$250 True Emergency (deductible does not apply)	$250 True Emergency (deductible does not apply)
Emergency Room - Non-emergency	$400 non-emergency (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Laboratory	WITH OR WITHOUT REFERRAL $0 co-pay at Quest Diagnostics	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME		
	IN-NETWORK	**OUT-OF-NETWORK**
Radiology (All other radiology services not listed above)	**Freestanding Diagnostic Facility (Steinberg):** $0 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not covered **All Other In-Network Providers:** Not covered	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
CAT Scan	**Freestanding Diagnostic Facility (Steinberg):** $50 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not Covered **All Other In-Network Providers:** Not Covered (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
MRI	**Freestanding Diagnostic Facility (Steinberg):** $75 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not Covered **All Other In-Network Providers:** Not Covered (deductible does not applicable)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
PET Scan	**Freestanding Diagnostic Facility (Steinberg):** $200 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not Covered **All Other In-Network Providers:** Not Covered	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*

* **Eligible Medical Expenses (EME):** The Eligible Medical Expenses (EME) are the amounts of the Provider's billed charges that the Trust will consider for payment.

ADDITIONAL LINE ITEMS	IN-NETWORK	OUT-OF-NETWORK
Acupuncture	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply), Limit of 20 visits per year	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Assistant Inpatient Surgeon	WITH OR WITHOUT REFERRAL 20% co-insurance after deductible	
Assistant Outpatient Surgeon	WITH OR WITHOUT REFERRAL 20% co-insurance after deductible	
Chemical Dependency, Mental Health Office Visit, Therapy	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply)	
Chemotherapy	WITH REFERRAL $20 co-pay (deductible does not apply) WITHOUT REFERRAL 20% co-insurance after deductible	
Chiropractic	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply), Limit of 20 visits per year	
Diabetic Education	WITH REFERRAL $0 co-pay (deductible does not apply) WITHOUT REFERRAL 20% co-insurance (deductible does not apply)	
Diagnostic Interpretation	NO REFERRAL NEEDED $0 co-pay	
Dialysis	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply)	
Hearing Aids	NO REFERRAL NEEDED Plan pays $1,000 per ear, every 5 years (deductible does not apply)	
In-Patient Routine Newborn Circumcision	NO REFERRAL NEEDED $20 co-pay (deductible does not apply)	
Inpatient surgeon	NO REFERRAL NEEDED 20% co-insurance after deductible	
Outpatient surgeon	NO REFERRAL NEEDED 20% co-insurance after deductible	
Inpatient Physician Visits	NO REFERRAL NEEDED 20% co-insurance after deductible	
Laboratory Pathology Interpretation	NO REFERRAL NEEDED $0 co-pay (deductible does not apply)	
Physical Therapy (Only when performed in an office. PT in a hospital facility falls under the hospital section)	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply), 20 Visits Per Year	
Prosthetic, Brace, Orthotic	NO REFERRAL NEEDED 20% (deductible does not apply)	
Radiation	WITH REFERRAL $20 co-pay (deductible does not apply)	
	WITHOUT REFERRAL 20% co-insurance after deductible	
Sleep Studies	WITH REFERRAL $75 co-pay (deductible does not apply) WITHOUT REFERRAL 20% co-insurance after deductible	
Transplant Services	$1,500 in addition to all other copayment/coinsurance	Not Covered