NETWORK PROVIDER BENEFIT

This Plan provides benefits through a group of contracted providers (Network Provider). Tier 1 includes the THT/WellHealth Network and Tier 2 includes the Cigna OAP Network. A "Network Provider" means a provider that agrees to provide services as part of an agreement. Using Network Providers offers cost-saving advantages because a Covered Person pays only a percentage of the scheduled fee for services provided.

Non-Network Provider means a provider who is not a Network Provider. There is no benefit for Non-Network Provider Services other than for Emergency Room Services which are payable the same as Tier 1.

To determine if a provider qualifies as a Network Provider under this Plan, please consult Allegiance's website at www.askallegiance.com/THT to access links for directories of Network Providers.

TRANSITION OF CARE

Certain Eligible Expenses that would have been considered at the Network benefit level by the prior claims administrator but which are not considered at the Network benefit level by the current Plan Supervisor may be paid at the applicable Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous Network but who is not a member of the Plan's current Network in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the Network medical plan benefit level may continue for ninety (90) days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

1. Cancer if under active treatment with chemotherapy and/or radiation therapy.

2. Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).

3. If the Covered Person is Inpatient in a Hospital on the effective date.

4. Post acute Injury or surgery with the past three (3) months.

5. Pregnancy in the second or third trimester and up to eight (8) weeks postpartum.

6. Behavioral health - any previous treatment.

7. Receiving care for end-stage renal disease or dialysis.

8. Terminally ill, with anticipated life expectancy of six months or less.

To be eligible for this benefit, call the utilization management company at (855) 999-1050.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

REFERRALS

A referral is required from a THT/WellHealth Primary Care Physician (PCP) for any specialty care services. Not obtaining a referral will result in higher out-of-pocket expenses.

SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE)

THE BENEFIT PERIOD IS A CALENDAR YEAR

COST SHARING PROVISIONS	TIER 1	TIER 2	NON-NETWORK
DEDUCTIBLE Per Covered Person per Benefit Period Per Family per Benefit Period	 $500 $1,500	 $1,500 $4,500	 No Benefit
The Deductible applies to all benefits unless specifically indicated as waived. Tier 1 and Tier 2 Deductibles are completely separate and do not cross accumulate.			
OUT-OF-AREA RETIREES DEDUCTIBLE Per Covered Person per Benefit Period Per Family per Benefit Period	 $500 $1,500	 $250 $750	 No Benefit
Out-of-Area Retiree is defined as a Retiree who resides outside the borders of Clark County, Nevada. The Deductible applies to all benefits unless specifically indicated as waived. Tier 1 and Tier 2 Out-of-Pocket Maximums are completely separate and do not cross accumulate.			
BENEFIT PERCENTAGE	80%	80%	No Benefit
The Benefit Percentage applies after Deductible is satisfied and applies to all benefits unless specifically stated otherwise. Benefits are payable at 100% after satisfaction of the Out-of-Pocket Maximum for the remainder of the Benefit Period.			
COPAYMENTS Copayments apply to certain services as specifically stated below in this section. Copayments apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.			
OUT-OF-POCKET MAXIMUM (Medical and Pharmacy Benefits) Per Covered Person per Benefit Period Per Family per Benefit Period	 $6,850 $13,700	 $7,900 $15,800	 No Benefit No Benefit
Includes the Deductible, Medical Benefit and Pharmacy Benefit Copayments and Tier 1 or Tier 2 Network Eligible Expenses in excess of the Benefit Percentage. Tier 1 and Tier 2 Out-of-Pocket Maximums are completely separate and do not cross accumulate.			
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None		
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None		

COST SHARING PROVISIONS	TIER 1	TIER 2	NON-NETWORK
PRE-CERTIFICATION/PRE-TREATMENT REVIEW Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted. See Hospital Admission Certification and Pre-Treatment Review for further details.			

CHRONIC CARE PROGRAMS
The Teachers Health Trust, in partnership with WellHealth, provides several Chronic Care Programs covering conditions that include Diabetes, Asthma/COPD, Congestive Heart Failure(CHF), Hypertension, Hyperlipidemia and High-Risk Pregnancy. Members must enroll in at least one of these programs to receive the following benefits when visiting any THT/WellHealth PCP or Specialty Care Physician. **Primary Care Physician or Specialty Care Physician:** 100%, Deductible Waived for the office visit. 80%, Deductible Waived for all other services. Further information and details about the Chronic Care Programs will be dispersed to members directly. For questions or concerns, please contact the Healthcare Advocate team at (855) 404-9355 or at WH_Advocates@hcpnv.com.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
ACUPUNCTURE TREATMENT			
	100% after $20 Copayment*, Deductible Waived	80% after Deductible	No Benefit
*Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). All other charges for services that are performed at the time of the visit or that are incurred in conjunction with the office visit, are subject to the applicable Benefit Percentage.			
Benefit Limits: 20 Visits per Benefit Period **Benefit limits are for services received from all benefit tiers.**			

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)			
CT Scan - Freestanding Diagnostic Facility	100% after $50 Copayment, Deductible Waived	80% after Deductible	No Benefit
CT Scan - All other Providers (with referral)	80%, Deductible Waived	80% after Deductible	No Benefit
CT Scan - All other Providers (without referral)	80% after Deductible	80% after Deductible	No Benefit
MRI/MRA - Freestanding Diagnostic Facility	100% after $75 Copayment, Deductible Waived	80% after Deductible	No Benefit
MRI/MRA - All other Providers (with referral)	80%, Deductible Waived	80% after Deductible	No Benefit
MRI/MRA - All other Providers (without referral)	80% after Deductible	80% after Deductible	No Benefit
PET Scan - Freestanding Diagnostic Facility	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
PET Scan- All other Providers (with referral)	80%, Deductible Waived	80% after Deductible	No Benefit
PET Scan- All other Providers (without referral)	80% after Deductible	80% after Deductible	No Benefit
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY			
Inpatient Facility Services	100% after $400 Copayment per day; $800 Copayment Maximum per admission, Deductible Waived	80% after Deductible	No Benefit
Inpatient/Outpatient - Professional Provider Services	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
Partial Hospitalization Services	100% after $150 Copayment per day; $900 Copayment Maximum per admission, Deductible Waived	80% after Deductible	No Benefit
Outpatient Facility Services	80%, Deductible Waived	80% after Deductible	No Benefit
Office Visit Services	100% after $10 Copayment, Deductible Waived	100% after $30 Copayment, Deductible Waived	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
ALLERGY TREATMENT			
Office visit Copayment applies when an office visit charge is assessed.	80%, Deductible Waived	80% after Deductible	No Benefit
AMBULANCE SERVICE			
Air Ambulance	80%, Deductible Waived		
Ground Ambulance	80%, Deductible Waived		
AMBULATORY SURGICAL CENTER			
	100% after $400 Copayment, Deductible Waived	80% after Deductible	No Benefit
BARIATRIC SURGERY			
	No Benefit	No Benefit	No Benefit
BIRTHING CENTER			
Facility Services	100% after $400 Copayment; Deductible Waived	80% after Deductible	No Benefit
Professional Provider Services	80% after Deductible	80% after Deductible	No Benefit
CARDIAC REHABILITATION THERAPY - OUTPATIENT			
	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
CARDIOLOGY NUCLEAR DIAGNOSTIC PROCEDURES - OUTPATIENT			
Hospital Facility Services	80%, Deductible Waived	80% after Deductible	No Benefit
All other Providers (with referral)	80%, Deductible Waived	80% after Deductible	No Benefit
All other Providers (without referral)	80% after Deductible	80% after Deductible	No Benefit
CHEMOTHERAPY - OUTPATIENT			
	80%, Deductible Waived	80% after Deductible	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
CHIROPRACTIC CARE			
Evaluation/Adjustment	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
Diagnostic Testing	80%, Deductible Waived	80% after Deductible	No Benefit
Benefit Limits: 20 Visits per Benefit Period. "Visit" includes all services provided during a calendar day, except for X-rays. **Benefit limits are for services received from all benefit tiers.**			
COLONOSCOPY AND ENDOSCOPIES			
Routine Colonoscopy	100%, Deductible Waived	80%, Deductible Waived	No Benefit
Diagnostic Colonoscopies and Endoscopies	80% after Deductible	80% after Deductible	No Benefit
CONTRACEPTIVES (Including Contraceptive Management)			
Administered during Office Visit	100%, Deductible Waived	80%, Deductible Waived	No Benefit
See Pharmacy Benefit for details if obtained from a Pharmacy.			
CVS MINUTE CLINICS			
	100% after $15 Copayment, Deductible Waived		No Benefit
Covered Persons may visit all CVS Minute Clinics nationwide; no referral is required. Minute Clinics are not meant to replace established care with your PCP. They are meant only as bridge care; to be utilized in place of a quick care facility or emergency rooms for non-emergent or life-threatening symptoms.			
DENTAL SERVICES (Accidental Injury Only)			
	Payable the same as regular benefit depending on the place of service and type of provider.		
DIABETIC EDUCATION			
	100%, Deductible Waived	80% after Deductible	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
DIAGNOSTIC TESTING - OUTPATIENT			
Laboratory at Quest diagnostics or dialysis lab	100%, Deductible Waived	80% after Deductible	No Benefit
Laboratory/Pathology - All other Providers	80%, Deductible Waived	80% after Deductible	No Benefit
Radiology - Freestanding Diagnostic Facility	100%, Deductible Waived	80% after Deductible	No Benefit
Radiology - All other Providers (with referral)	80%, Deductible Waived	80% after Deductible	No Benefit
Radiology - All other Providers (without referral)	80% after Deductible	80% after Deductible	No Benefit
DIALYSIS TREATMENTS - OUTPATIENT			
Physician/Nephrologist	100% after $20 Copayment*, Deductible waived	80% after Deductible	No Benefit
Facility/Hospital	80%, Deductible Waived	80% after Deductible	No Benefit
CAPD, CCPD, Home Dialysis including training, Physician evaluation, ultrafiltration and supplies	100% after $20 Copayment*, Deductible waived	80% after Deductible	No Benefit
*Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). All other charges for services that are performed at the time of the visit or that are incurred in conjunction with the office visit, are subject to the applicable Benefit Percentage. **Note:** Covered Persons are strongly encouraged to enroll in Medicare Part B to avoid potential billing that is not covered by the Plan.			
EMERGENCY ROOM SERVICES			
Facility Services for Emergency as defined	100% after $250 Copayment*, Deductible Waived		
Professional Provider Services for Emergency as defined	80% after Tier 1 Deductible		
Facility Services for non-emergency	100% after $400 Copayment, Deductible Waived		No Benefit
Professional Provider Services for non-emergency	80% after Tier 1 Deductible		No Benefit
*Copayment is waived if admitted as Inpatient immediately following the emergency room.			

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
EYE EXAMINATION FOR REFRACTORY CONDITIONS AND RETINAL SCREENING			
	No Benefit	No Benefit	No Benefit
GENETIC TESTING - OUTPATIENT (Not otherwise covered under Preventive Care)			
Professional Provider Services (with referral)	80%, Deductible Waived	80% after Deductible	No Benefit
Professional Provider Services (without referral)	80% after Deductible	80% after Deductible	No Benefit
Standalone Lab	100%, Deductible Waived	80% after Deductible	No Benefit
HEARING AIDS (Includes exam and fitting)			
	100%, Deductible Waived		No Benefit
Benefit Limits: $2,500 Maximum Benefit per ear every 3 Benefit Periods **Benefit limits are for services received from all benefit tiers.**			
HEARING EXAMINATIONS (Not otherwise covered under the Preventive Care Benefit)			
Routine Hearing Exam	No Benefit	No Benefit	No Benefit
Diagnostic Test	80% after Deductible	80% after Deductible	No Benefit
HOME HEALTH CARE			
	80%, Deductible Waived	80% after Deductible	No Benefit
HOSPICE CARE			
	80%, Deductible Waived	80% after Deductible	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
HOSPITAL SERVICES			
Inpatient Facility Services	100% after $400 Copayment per day; $800 Copayment Maximum per admission, Deductible Waived	80% after Deductible	No Benefit
Inpatient Primary Care Physician Services	100%, Deductible Waived	80% after Deductible	No Benefit
Inpatient All Other Physician Services	80% after Deductible	80% after Deductible	No Benefit
Outpatient Facility Services	80%, Deductible Waived	80% after Deductible	No Benefit
Outpatient Primary Care Physician Services	100%, Deductible Waived	80% after Deductible	No Benefit
Outpatient Radiologist/Pathologist Services	100%, Deductible Waived	80% after Deductible	No Benefit
Outpatient All Other Physician Services Not Listed Above	80% after Deductible	80% after Deductible	No Benefit
INFERTILITY TREATMENT (beyond diagnosis)			
	No Benefit	No Benefit	No Benefit
INFUSION SERVICES - OUTPATIENT			
Administration Services, Infusion drugs, nutrition and Physician office and infusion clinic	80%, Deductible Waived	80% after Deductible	No Benefit
MAMMOGRAMS			
Routine Mammograms	100%, Deductible Waived	80%, Deductible Waived	No Benefit
Diagnostic Mammograms	See Diagnostic Testing		
MASSAGE THERAPY (Services of a massage therapist)			
	No Benefit	No Benefit	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
MEDICAL EQUIPMENT/SUPPLIES			
Durable Medical Equipment	80%, Deductible Waived	80% after Deductible	No Benefit
Prosthetic Appliances	80%, Deductible Waived	80% after Deductible	No Benefit
Orthopedic Devices	80%, Deductible Waived	80% after Deductible	No Benefit
Other Medical Supplies	80%, Deductible Waived	80% after Deductible	No Benefit
Benefit Limits: **Compression Garments:** Limited to 4 per limb per Benefit Period **Bras:** Limited to 2 per Benefit Period **Breast Prosthesis:** Limited to 1 per breast every two Benefit Periods **Prosthesis:** As part of bra limited to 2 per Benefit Period **Benefit limits are for services received from all benefit tiers.**			
MENTAL ILLNESS			
Inpatient Facility Services	100% after $400 Copayment per day; $800 Copayment Maximum per admission, Deductible Waived	80% after Deductible	No Benefit
Inpatient/Outpatient - Professional Provider Services	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
Partial Hospitalization Services	100% after $150 Copayment per day; $900 Copayment Maximum per admission, Deductible Waived	80% after Deductible	No Benefit
Outpatient Facility Services	80%, Deductible Waived	80% after Deductible	No Benefit
Electroconvulsive Therapy (ECT)	80%, Deductible Waived	80% after Deductible	No Benefit
Psychosocial Rehabilitation/Autism Services	100% after $10 Copayment, Deductible Waived	80% after Deductible	No Benefit
Office Visit Services	100% after $10 Copayment, Deductible Waived	100% after $30 Copayment, Deductible Waived	No Benefit
NATUROPATHY/HOMEOPATHIC			
	No Benefit	No Benefit	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
NUTRITIONAL COUNSELING (Not otherwise covered under the Preventive Care Benefit or Diabetic Education)			
Registered Dietician	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
Benefit Limits: 6 Visits per Benefit Period **Benefit limits are for services received from all benefit tiers.**			
OCCUPATIONAL THERAPY - OUTPATIENT			
	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
OFFICE VISIT			
Primary Care Physician (Office Visit Charge)	100% after $10 Copayment*, Deductible Waived	100% after $30 Copayment*, Deductible Waived	No Benefit
Specialty Care Physician (Office Visit Charge with referral)	100% after $20 Copayment*, Deductible Waived	80% after Deductible	No Benefit
Specialty Care Physician (Office Visit Charge without referral)	80% after Deductible	80% after Deductible	No Benefit
Additional office charges other than office visit charge including allergy injections, diagnostic testing and office surgery (with referral)	80%, Deductible Waived	80% after Deductible	No Benefit
Additional office charges other than office visit charge including allergy injections, diagnostic testing and office surgery (without referral)	80% after Deductible	80% after Deductible	No Benefit
*Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). Other than Sleep Study, all other charges for services that are performed at the time of the visit or that are incurred in conjunction with the office visit, are subject to the applicable Benefit Percentage.			
ORGAN AND TISSUE TRANSPLANT SERVICES **Tier 1 is limited to a Center of Excellence**			
Hospital and Professional Provider Services	100% after $1,500 Copayment, Deductible Waived	No Benefit	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
ORTHOTICS (Foot)			
	80%, Deductible Waived	80% after Deductible	No Benefit
Benefit Limits: 1 per foot per Benefit Period. Benefit Limit is waived if enrolled in the Diabetic Program. **Benefit limits are for services received from all benefit tiers.**			
PEDIATRIC SERVICES			
Routine Newborn Inpatient Nursery (Applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.)	100%, Deductible Waived	80% after Deductible	No Benefit
Inpatient Physician Care	80%, Deductible Waived	80% after Deductible	No Benefit
Inpatient or Outpatient Newborn Circumcision	80%, Deductible Waived	80% after Deductible	No Benefit
Physicians Office Visits due to Illness or Injury	100% after $10 Copayment, Deductible Waived	100% after $30 Copayment, Deductible Waived	No Benefit
PHYSICAL THERAPY - OUTPATIENT			
	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
PREGNANCY/MATERNITY SERVICES **See Preventive Care Benefit for well-women prenatal visits.**			
Office Visit (if not part of a global fee)	100% after $10 Copayment*	100% after $30 Copayment*, Deductible Waived	No Benefit
Professional Provider Services (if billed as global fee)	80%, Deductible Waived	80% after Deductible	No Benefit
Inpatient Facility Services	100% after Deductible	80% after Deductible	No Benefit
Perinatologist Office Services Normal Pregnancy (with referral	100% after $20 Copayment*, Deductible Waived	80% after Deductible	No Benefit
Perinatologist Office Services High Risk Pregnancy (with referral	100%, Deductible Waived	80% after Deductible	No Benefit
Perinatologist Office Services (without referral	80% after Deductible	80% after Deductible	No Benefit
Perinatologist Hospitalist Services	80% after Deductible	80% after Deductible	No Benefit
Ultrasounds - Freestanding Diagnostic Facility	100%, Deductible Waived	80% after Deductible	No Benefit
Ultrasounds - All other Providers	80%, Deductible Waived	80% after Deductible	No Benefit
*Copayment applies only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other Outpatient setting). All other charges for services that are performed at the time of the visit or that are incurred in conjunction with the office visit, are subject to the applicable Benefit Percentage.			
PRESCRIPTION DRUGS - SEE PHARMACY BENEFIT FOR DETAILS			

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
PREVENTIVE CARE			
	100%, Deductible Waived	80%, Deductible Waived	No Benefit
Covered Services: ▫ Well-Child Care ▫ Physical examinations ▫ Pelvic examination and pap smear ▫ Laboratory and testing ▫ Hearing and vision screening, up to age 18 ▫ Mammogram ▫ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ▫ Cardiovascular screening blood tests ▫ Colorectal cancer screening tests ▫ Vaccinations and Immunizations recommended by Physician ▫ BRCA1 and BRCA2 when medically indicated ▫ Nutritional counseling ▫ Well Women Preventive Care Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/ If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.			
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY			
	No Benefit	No Benefit	No Benefit
RADIATION THERAPY- OUTPATIENT			
	80%, Deductible Waived	80% after Deductible	No Benefit
RESIDENTIAL TREATMENT FACILITY			
Residential Treatment Facility	100% after $150 Copayment per day; $900 Copayment Maximum per admission, Deductible Waived	80% after Deductible	No Benefit
Outpatient Half-Day Treatment, Comprehensive Day Treatment	100% after $20 Copayment, Deductible waived	80% after Deductible	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
RESPIRATORY/PULMONARY THERAPY - OUTPATIENT			
	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
SKILLED NURSING FACILITY			
	100% after $150 Copayment per day; $900 Copayment Maximum per admission, Deductible Waived	80% after Deductible	No Benefit
SLEEP STUDIES			
Office Visit	See Office Visit		No Benefit
Sleep Study Diagnostic Test	100% after $75 Copayment*, Deductible Waived	80% after Deductible	No Benefit
Facility	80%, Deductible Waived	80% after Deductible	No Benefit
*Copayment applies only to the sleep study diagnostic test.			
SPEECH THERAPY - OUTPATIENT			
	100% after $20 Copayment, Deductible Waived	80% after Deductible	No Benefit
STERILIZATION PROCEDURES			
Female Sterilization Procedures	100%, Deductible Waived	80%, Deductible Waived	No Benefit
Vasectomy	80%, Deductible Waived	80% after Deductible	No Benefit
SURGERY - OUTPATIENT			
Same Day Surgery Facility	100% after $400 Copayment, Deductible Waived	80% after Deductible	No Benefit
Outpatient Surgery with Inpatient Surgical Recovery Suite	100% after $1,400 (Global Copayment amount), Deductible Waived	80% after Deductible	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT TIER 1	TIER 2	NON-NETWORK
TELEMEDICINE/TELETHERAPY			
WellHealth/MDLive Consultations	100%, Deductible Waived	N/A	N/A
For further details, please consult www.mdlive.com/allegiance or call (877) 753-7992.			
Telemedicine other than WellHealth/MDLive	No Benefit	No Benefit	No Benefit
TMJ/JAW DISORDERS (Non-surgical treatment only)			
Diagnostic Testing	See Diagnostic Testing		
TMJ appliance is covered under Dental Benefits.			
URGENT CARE FACILITY			
	100% after $50 Copayment*, Deductible Waived		No Benefit
*Copayment applies to all charges for services provided at the Urgent Care Facility.			
VISION SERVICES (initial purchase of eyeglasses following a Medically Necessary surgical procedure to the eye, cataract surgery or for aphakic patients, soft lenses or sclera shells intended for use as corneal bandages)			
	80%, Deductible Waived	80% after Deductible	No Benefit
WEIGHT LOSS PROGRAMS			
	No Benefit	No Benefit	No Benefit
WELL-CHILD CARE			
	See Preventive Care Benefit		
WIG/HAIRPIECE (Loss of hair as a result of a medical condition or Medically Necessary treatment)			
	100%, Deductible Waived		
Benefit Limits: $1,000 Maximum Benefit per condition or course of treatment. **Benefit limits are for services received from all benefit tiers.**			

PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. Pharmacy Copayments do not serve to satisfy the Medical Benefits Annual Deductible. However, Pharmacy Copayments do apply toward the combined Out-of-Pocket Maximum for Medical Benefits and Pharmacy Benefits. **The Pharmacy Benefit Manager (PBM) will provide separate information for details regarding Network pharmacies, Preferred drugs and Specialty Drugs upon enrollment for coverage under this Plan.**

To determine coverage for medication, contact MedImpact at 1-844-336-2676 or visit https://mp.medimpact.com.

COST SHARING PROVISIONS

Pharmacy Deductible per Benefit Period . . . . . None

Out-of-Pocket Maximum per Benefit Period (Combined with Medical Benefits)
Per Covered Person $6,850*
Per Family $13,700*

*The Out-of-Pocket Maximum is combined for Pharmacy Benefits and Medical Benefits and includes any applicable Pharmacy Copayments. Pharmacy Benefits are payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum for the remainder of the Benefit Period.

Exclusive Network Retail Pharmacies - Copayment per Prescription (30-Day Supply Maximum) CVS, Walmart, Sam's Club, Von's, and Lin's Supermarket (Overton, NV)	
Generic Drugs: Cost Up to $25	$5 per 30-day supply
Generic Drugs: Cost Over $25	25%, Copayment maximum $50 per 30-day supply
Preferred (Formulary)	25%, Copayment maximum of $100 per 30 day supply
Non-Preferred Brand	40%, cost of prescription minimum $50 per 30-day supply
Formulary Diabetic Supplies (Includes Syringes, Needles, Lancets and Test Strips; Limited to a quantity of 200 per 30-day supply)	If enrolled in WellHealth Diabetic Program: $0 Copayment; If not enrolled in WellHealth Diabetic Program: $10 Copayment Glucose monitors are provided, at no charge to the Covered Person, by the Trust. Call (702) 866-6192 to make an appointment.
Formulary Diabetics Insulin and Medications	25% of the cost of the prescription. If enrolled in and compliant with the WellHealth Diabetic Program: $100 maximum per prescription per 30-day supply. If not enrolled in and compliant with the WellHealth Diabetic Program: $200 maximum per prescription per 30-day supply.

Emergency Drug List (30-Day Supply Maximum)	
Emergency Drug List: Epi-Pen, Epi-Pen Jr., Glucagon Emergency Kit and Narcan Nasal Spray	25%, Copayment maximum $100 per 30-day supply
The Emergency Drug Lists provides access to high-cost emergency drugs that are on formulary, but often a requirement for specific conditions and/or illnesses. These drugs are provided with a lower maximum despite being non-preferred brands in order to assist in managing the costs of life-saving essential drugs.	

Network Retail Pharmacies other than Exclusive Network Retail Pharmacies	
Pharmacy Choice Fee	$10 Copayment per prescription
For prescriptions filled at network pharmacies other than CVS, Walmart, Sam's Club, Von's, and Lin's Supermarket (Overton, NV), the Covered Person will pay a pharmacy choice fee (PCF) of $10 per prescription in addition to the applicable Copayments. A complete listing of non-preferred in-network pharmacies and formulary medications are available at https://mp.medimpact.com. Copayment does not apply towards the Out-of-Pocket Maximum.	

Preventive Drugs

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed generic contraceptives or brand if generic is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/

Specialty Drugs - 30-Day Supply Maximum	
Generic Drugs	25%, Copayment maximum $500
Preferred (Formulary)	25%, Copayment maximum of $500
Non-Preferred Brand	40%, cost of prescription minimum $50

Mail Order Program - 90-Day Supply Maximum	
Generic Drugs: Cost Up to $75	$12.50
Generic Drugs: Cost Over $75	25%, Copayment maximum $150
Preferred (Formulary)	25%, Copayment maximum of $300
Non-Preferred Brand	40%, cost of prescription minimum $125
Formulary Diabetic Supplies (Includes Syringes, Needles, Lancets and Test Strips; Limited to a quantity of 200 per 30-day supply)	If enrolled in WellHealth Diabetic Program: $0 Copayment; If not enrolled in WellHealth Diabetic Program: $30 Copayment Glucose monitors are provided, at no charge to the Covered Person, by the Trust. Call (702) 866-6192 to make an appointment.
Formulary Diabetics Insulin and Medications	25% of the cost of the prescription. If enrolled in and compliant with the WellHealth Diabetic Program: $300 maximum per prescription per 30-day supply. If not enrolled in and compliant with the WellHealth Diabetic Program: $600 maximum per prescription per 30-day supply.

If the Dispense as Written (DAW) box on the prescription is marked by either the Covered Person or the Physician with a brand drug, it will automatically be filled with a brand-name drug and Covered Person will be responsible for the difference between the brand and generic cost plus the brand name Copayment.

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Self-administered contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider.

   Contraceptive Management, injectable contraceptives and contraceptive devices are covered under the Medical Benefits of this Plan.

2. Legend vitamins (oral only): Prenatal agents used in Pregnancy.

3. Diabetic supplies, including syringes, needles, pen needles, test strips, urine glucose test strips, urine acetone test strips, lancets and lancet devices.

4. Blood monitors and kits. Blood monitors and kits are also eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan. Glucose monitors are provided, at no charge to the Covered Person, by the Trust. Call (702) 866-6192 to make an appointment.

5. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider.

6. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/

7. Erectile dysfunction, limited to 8 pills per month.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

Exclusive Network or PBM Retail Network Prescriptions: Available only through a retail pharmacy that is part of the Exclusive Network or PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.**

Specialty Drug(s): These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs must be obtained from a preferred specialty pharmacy. **Only the first prescription can be obtained at a network retail pharmacy. All subsequent refills must be obtained through a preferred specialty pharmacy. A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.**

Out-of-Network Retail Pharmacies: Not covered.

MEMBER SUBMIT PRESCRIPTIONS

Member Submit is available only if the prescription identification card is not used at a PBM pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.**

MedImpact Prescription Reimbursement forms can be found on the Trust website at www.teachershealthtrust.org.

DEFINITIONS

Exclusive, Network and Non-Preferred Retail Pharmacies: Exclusive pharmacies which are contracted include CVS, Walmart, Sam's Club, Von's, and Lin's Supermarket (Overton, NV). A complete list including Preferred and Non-Preferred Retail pharmacies is available on MedImpact's website at https://mp.medimpact.com.

Generic: A drug that contains the same active ingredients as and is equivalent in strength and dosage to the original brand name drug.

Preferred Drugs: Drugs that have been carefully selected based on their clinical effectiveness and cost savings to the Covered Person and the Trust. The Copayments for Preferred Drugs are lower than the Copayments for Non-Preferred Drugs. A list of Preferred Drugs is sometimes known as a "Formulary".

Non-Preferred Drugs: Drugs that are not on the Preferred Drug list. The Copayments for Non-Preferred Drugs are higher than the Copayments for Preferred Drugs.

Out-of-Network Retail Pharmacies: Independently owned pharmacies and chain pharmacies which are not contracted by MedImpact on behalf of the Trust.

COPAYMENT

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. Copayments are specifically stated in this section. Copayments are not payable by the Plan and do not serve to satisfy the Medical Benefits Deductible. However, Pharmacy Copayments do apply towards the combined Out-of-Pocket Maximum for Medical Benefits and Pharmacy Benefits and after satisfaction of the Out-of-Pocket Maximum, Copayments will no longer apply for the remainder of the Benefit Period.

PRIMARY COVERAGE UNDER ANOTHER PLAN

When primary coverage exists under another Plan, #including Medicare Part D, charges for prescription drugs may be reimbursed by the Plan as specifically stated in this section, subject to the following conditions:

1. Charges for prescription drugs must be submitted to the primary carrier first.

2. The prescription drug receipt and explanation of benefits from primary carrier showing the total charges and amounts paid for eligible prescription drugs, along with a reimbursement form must be submitted to Allegiance Benefit Plan Management, Inc, ##or through the Pharmacy Benefit Manager (PBM) if primary coverage is Medicare Part D. This Plan will reimburse the Participant for the remainder of Eligible Expenses subject to the Copayments stated in this section. **In order to receive reimbursement, the drug receipt must be submitted to Allegiance, or through the Pharmacy Benefit Manager (PBM) if primary coverage is Medicare Part D.**

3. The pharmacy indicates either "generic" or "brand" on the prescription drug receipt.

4. The primary coverage information has been previously submitted to the Plan.

Charges for prescription drugs are not eligible if the above conditions are not met.

SUPPLY LIMITS

Supply is limited to 30 days for Network Retail prescriptions and Specialty Drugs and 90-day supply for Mail Order Prescriptions.

Prescription drug refills are not allowed until 75% of the prescribed day supply is used.

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. Any additional prescribed supply exceeding any clinically appropriate limits will be reviewed for Medical Necessity. A current list of applicable quantity limits can be obtained by contacting the PBM at the number listed on the Participant's identification card.

PRIOR AUTHORIZATION

Certain drugs require approval before the drug can be dispensed. A current list of drugs that require Prior Authorization can be obtained by contacting the PBM at the number listed on the Participant's identification card.

Drug Detox Protocol: Medications used to aid in detoxification of drugs and alcohol are covered under the prescription drug plan only when prior authorization is obtained through Human Behavior Institute (HBI).

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Cosmetic only indications including, but not limited to, photo-aged skin products (Renova); hair growth or hair removal agents (Propecia, Vaniqa); and injectable Cosmetics (Botox Cosmetic).

2. Dermatology: Agents used in the treatment of acne and/or for Cosmetic purposes for Covered Persons twenty-six (26) years or older or depigmentation products used for skin conditions requiring a bleaching agent.

3. Legend homeopathic drugs.

4. Fertility agents, oral, vaginal and injectable.

5. Weight management.

6. Serums and toxoids unless there is an approved FDA NDC present.

7. Legend vitamins or fluoride, except as specifically covered.

8. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered.

9. Durable Medical Equipment.*

10. Experimental or Investigational drugs.

11. Abortifacient drugs.

12. Compounded pharmaceuticals containing bulk chemicals.

13. Anabolic sterioids.

14. Medications used to aid detoxification from drugs or alcohol or in replacement of desired drug (such as methadone or Suboxone), except as covered through the drug detox protocol.

15. The following Drug Classes are Not Covered: Non-Sedating Antihistamines, Proton Pump Inhibitors, Nonsterodial Antiinflammatory Agents (NSAIDs) and, Nasal Steroids.

16. Irrigation solutions.

*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

NON-FORMULARY EXCLUSION

Certain drugs may be excluded by the Plan's Pharmacy Benefit Manager (PBM). Those exclusions are based upon the PBM's clinical research regarding the efficacy of the drug as compared to other similar drugs, the availability of the drug, and clinical prescribing rules. Drugs excluded under this basis may be covered if a request for Prior Authorization is made, or if a denial of coverage for the drug is appealed under the claims and appeals procedures of this Plan.

SCHEDULE OF DENTAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

Dental benefits are subject to Eligible Dental Expenses (EDE) which are the amounts of the dental provider's billed charges that the Trust will consider for payment. Network providers EDE is the contracted amount agreed upon by the provider. Non-Network is the dental fee schedule established by the Trust.

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND LIMITATIONS OF THE PLAN AND ELIGIBLE DENTAL EXPENSES (EDE)

THE BENEFIT PERIOD IS A CALENDAR YEAR

DEDUCTIBLE . . . . . None

DENTAL EXPENSES

Type A (Preventive Care) Dental Expenses
Benefit Percentage 100%

Type B (Basic Care) Dental Expenses
Benefit Percentage 80%

Type C (Major Restorative) Dental Expenses
Benefit Percentage 60%

DENTAL MAXIMUMS

Type A, B and C Maximum Benefit per Benefit Period $1,500

TMJ Appliance Maximum Lifetime Benefit $500

ORTHODONTIC TREATMENT BENEFIT
(Dependents age 18 and under)

Benefit Percentage 100%
Maximum Lifetime Benefit $1,000

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

Services, treatments or supplies are eligible for coverage if they meet all of the following requirements:

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and

3. Charges do not exceed the Eligible Expense of the Plan; and

4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by the Plan Administrator prior to beginning such treatment. Prior approval is limited to medically accepted non-experimental or investigational treatments, services, or supplies, which, in the opinion of the Plan Administrator, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE

The Deductible is stated in the Schedule of Medical Benefits and applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. Also, if members of a Family have satisfied individual Deductible amounts that collectively equal the Deductible per Family, as stated in the Schedule of Medical Benefits, during the same Benefit Period, no further Deductible will apply to any member of that Family during that Benefit Period. **An individual Covered Person cannot receive credit toward the Family Deductible for more than the Individual Annual Deductible as stated in the Schedule of Medical Benefits.**

BENEFIT PERCENTAGE

The Benefit Percentage is stated in the Schedule of Medical Benefits. The Plan will pay the Benefit Percentage of the Eligible Expense indicated.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes amounts applied toward the Deductible, amounts in excess of the Benefit Percentage paid by the Plan and all applicable Copayments for Medical Benefits. Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, will be paid at 100% of the Eligible Expense for the remainder of the Benefit Period. **An individual Covered Person cannot receive credit toward the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits.**

COPAYMENT

Copayments are stated in the Schedule of Medical Benefits. Copayments are first-dollar amounts that are payable for certain covered services under the Plan which are usually paid at the time the service is performed (e.g., physician office visits or emergency room visits). These Copayments do not apply towards the Medical Benefits Deductible but do apply towards the Medical Benefits Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.

MAXIMUM BENEFIT

The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles will be applied to Eligible Expenses Incurred in the chronological order in which they are adjudicated by the Plan. Eligible Expenses Incurred will be paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Eligible Expenses are paid by the Plan will be conclusive and binding on all Covered Persons and their assignees.

CHANGES IN COVERAGE CLASSIFICATION

A change in coverage that decreases a benefit of this Plan will become effective on the stated effective date of such change with regard to all Covered Persons to whom it applies.

NEW YORK STATE EXPENSES

This Plan has voluntarily elected to make public goods payments directly to the Office of Pool Administration in conformance with HCRA provisions and New York State Department of Health (Department) requirements.

TEACHERS HEALTH TRUST
PLAN SUMMARY

The following information, together with the information contained in this booklet, form the Summary Plan Description.

1. PLAN

The name of the Plan is TEACHERS HEALTH TRUST, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

This Plan provides benefits for Eligible Expenses Incurred by eligible participants for:

Hospital, Surgical, Medical, Maternity, Dental other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

This Plan was established effective January 1, 1983, and restated January 1, 2019.

4. PLAN SPONSOR

Name: Teachers Health Trust
Phone (702) 866-6165
Address: P.O. Box 96238
Las Vegas, Nevada 89193-6238

5. PLAN ADMINISTRATOR

Name: Teachers Health Trust Board of Trustees
Phone (702) 866-6165
Address: P.O. Box 96238
Las Vegas, Nevada 89193-6238

6. NAMED FIDUCIARY

Name: Teachers Health Trust Board of Trustees
Phone (702) 866-6165
Address: P.O. Box 96238
Las Vegas, Nevada 89193-6238

7. PLAN FISCAL YEAR

The Plan fiscal year ends December 31st.

8. PLAN TERMINATION

The right is reserved by the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

9. IDENTIFICATION NUMBER

Group Number: 2001042
Employer Identification Number: 88-0195176

10. PLAN SUPERVISOR

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806

11. ELIGIBILITY

Employees and Dependents of Employees of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

12. PLAN FUNDING

The Plan is funded by contributions from THT and Employees.

13. AGENT FOR SERVICE OF LEGAL PROCESS

Teachers Health Trust Chief Executive Officer is the agent for service of legal process.

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