Medical Benefit - Deductible, Copay and Coinsurance Overview

A brief reference guide of the Teachers Health Trust Performance Plus Plan for quick and easy answers when you need them.

Medical Benefit Copayment and Coinsurance Overview

A brief reference guide for the Teachers Health Trust medical benefits

Plan Document

The full plan document can be found on the Teachers Health Trust website. The following is a summary description of the deductible and out-of-pocket benefits.

Calendar Year Deductible	Per Individual Per Calendar Year	In-Network	$600
		Out-Of-Network	$2,500
	Per Family Per Calendar Year	In-Network	$1,800
		Out-Of-Network	$10,000
Calendar Year Total Out-of-Pocket	Per Individual Per Calendar Year	In-Network	$6,850
		Out-Of-Network	No Maximum
	Per Family Per Calendar Year	In-Network	$13,700
		Out-Of-Network	No Maximum

Medical Benefit Copayment and Coinsurance Overview (continued...)

A brief reference guide for the Teachers Health Trust medical benefits

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. See 89-95 for more information. Your chosen PCMH provider will be a Primary Care Physician (PCP), Family Practice, Internal Medicine, or Pediatrician Provider. Services included in the "Office Visit Copayment" include charges for the office visit or consult only. 20% coinsurance applies to all other services such as, but not limited to, urinalysis, pulse oximetry, administration of injections, medications, procedures, surgery, and testing.

Preventive Care	In-Network	$0 copay for office visit (deductible does not apply)
PCP Provider *(Inpatient or Outpatient Services)*	In-Network	$10 copay for office visit (deductible does not apply); and 20% coinsurance for all other services (deductible does not apply)
Specialist Physician *(In Physician's Office)*	In-Network	$20 copay for office visit **with referral** (deductible does not apply); and 20% coinsurance for all other services (deductible does not apply).
Specialist Physician *(Out of Physician's Office)*	In-Network	20% coinsurance after $600 deductible.
Medical Home Identified Chronic Condition Patients *(Primary Care or Specialist Physician Office Visit - Diabetes, Hight-Risk, Preganancy, Cardiovascular, COPD and Asthma)*	In-Network	$0 copay for office visit (deductible does not apply) 20% coinsurance for all other services (deductible does not apply)

Medical Benefit Copayment and Coinsurance Overview (continued...)

A brief reference guide for the Teachers Health Trust medical benefits

In-Office Surgery	In-Network	20% coinsurance **with referral** from PCMH PCP (deductible does not apply)
Obstetrician Services - OB/GYN, Inpatient or Outpatient Services *(pregnancy, prenatal, delivery and post-natal: Normal Pregnancy)*	In-Network	$10 copay for office visits applies, if billed separately from complete delivery services; 20% coinsurance for all other services (deductible does not apply)
ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME		
Preventive Care	In-Network	$0 copay for office visit (deductible does not apply)
	Out-Of-Network	Not Covered
Specialist Physician	In-Network	WITHOUT REFERRAL - 20% coinsurance after deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Office Surgery	In-Network	WITHOUT REFERRAL - 20% coinsurance after deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

Medical Benefit Copayment and Coinsurance Overview (continued...)

A brief reference guide for the Teachers Health Trust medical benefits

Obstetricians Services other than Your Chosen PCMH *(pregnancy, prenatal, delivery and post-natal)*	In-Network	$10 copay for office visits applies, if billed separately from complete delivery services; 20% coinsurance for all other services (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

Anesthesia	In-Network	WITH OR WITHOUT REFERRAL - 20% coinsurance after deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

Facility *(Includes Skilled Nursing and Mental Health/Chemical Dependency Facilities, Inpatient Outpatient, Ambulatory Surgical Center, Long-Term Acute Care, or Acute Rehabilitation)* **When there is no facility copay; applicable copay and or coinsurance will apply:**	In-Network	WITH OR WITHOUT REFERRAL - $400 per day; $800 Max Per Stay (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Outpatient services *(such as but not limited to; clinics; radiation; radiology services; chemotherapy; sleep studies; physical, occupational and speech therapy; and testing)*	20% coinsurance (deductible does not apply)	

Medical Benefit Copayment and Coinsurance Overview (continued...)

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Home Health/Hospice/Insulation	In-Network	WITH OR WITHOUT REFERRAL - 20% coinsurance (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Durable Medical Equipment - prosthetics, braces and orthotics, including foot orthotics	In-Network	WITH OR WITHOUT REFERRAL - 20% coinsurance (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Urgent Care	In-Network	NO REFERRAL REQUIRED - $50 copay (deductible does not apply)
	Out-Of-Network	NO REFERRAL REQUIRED - $75 copay (deductible does not apply)
Minute Clinic	In-Network	NO REFERRAL REQUIRED - $15 copay (deductible does not apply)
	Out-Of-Network	NO REFERRAL REQUIRED - $15 copay (deductible does not apply)
Telemedicine (MDLive)	In-Network	$0 copay
	Out-Of-Network	N/A

Medical Benefit Copayment and Coinsurance Overview (continued...)

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Emergency Room - True Emergency	In-Network	$250 True Emergency (deductible does not apply)
	Out-Of-Network	$250 True Emergency (deductible does not apply)
Emergency Room - Non-Emergency	In-Network	$400 copay non-emergency (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Laboratory	In-Network	WITH OR WITHOUT REFERRAL - $0 copay at Quest Diagnostics
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Radiology	In-Network	**Freestanding Diagnostic Facility:** $0 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) Radiology coinsurance only applies when Facility copay does not. **PCP Office:** 20% coinsurance - X-rays of chest, spine, pelvis and extremities, abdomen; ultrasound of abdomen, dexa bone density (deductible does not apply) All other radiology services in PCP office are not covered. **All Other In-Network Providers:** 20% coinsurance with a referral (deductible does not apply); 20% coinsurance after $600 deductible without a referral
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

Medical Benefit Copayment and Coinsurance Overview (continued...)

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CAT Scan	In-Network	**Freestanding Diagnostic Facility:** $50 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) Radiology coinsurance only applies when Facility copay does not. **PCP Office:** Not Covered **All Other In-Network Providers:** 20% with a referral (deductible does not apply); 20% coinsurance after $600 deductible without a referral
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
MRI	In-Network	**Freestanding Diagnostic Facility:** $75 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) Radiology coinsurance only applies when Facility copay does not. **PCP Office:** Not Covered **All Other In-Network Providers:** 20% with a referral (deductible does not apply); 20% coinsurance after $600 deductible without a referral
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Acupuncture	In-Network	WITH OR WITHOUT REFERRAL - 20% copay (deductible does not apply), Limit of 20 visits per calendar yer
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

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Chemical Dependency Counseling, Mental Health Office Visit, Therapy	In-Network	WITH OR WITHOUT REFERRAL - $20 copay (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Chemotherapy	In-Network	WITH REFERRAL - $20 copay (deductible does not apply) WITHOUT REFERRAL - 20% coinsurance after $600 deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Radiation	In-Network	WITH REFERRAL - $20 copay (deductible does not apply) WITHOUT REFERRAL - 20% coinsurance after $600 deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Chiropractic	In-Network	WITH OR WITHOUT REFERRAL - 20% copay (deductible does not apply), Limit of 20 visits per calendar year
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Diabetic Education	In-Network	WITH REFERRAL - $0 copay (deductible does not apply) WITHOUT REFERRAL - 20% coinsurance (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

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Dialysis	In-Network	WITH OR WITHOUT REFERRAL - $20 copay (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Hearing Aids	In-Network	NO REFERRAL NEEDED - Plan pays $1,000 per ear, every 5 years (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Inpatient Surgeon	In-Network	NO REFERRAL NEEDED - 20% coinsurance after $600 deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Outpatient Surgeon	In-Network	NO REFERRAL NEEDED - 20% coinsurance after $600 deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Inpatient Physician Visits *(Specialist)*	In-Network	NO REFERRAL NEEDED - 20% coinsurance after $600 deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Laboratory Pathology/Radiology Interpetation *(Inpatient)*	In-Network	NO REFERRAL NEEDED - $0 copay (deductible does not apply)
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

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Physical Therapy *(Only when performed in an office. PT in a hospital facility falls under the hospitals section)*	In-Network	WITH OR WITHOUT REFERRAL - $20 copay (deductible does not apply), 20 visits per year
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Sleep Studies *(In-Office)*	In-Network	WITH REFERRAL - $75 copay (deductible does not apply) WITHOUT REFERRAL - 20% coinsurance after $600 deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Sleep Studies *(Facility)*	In-Network	WITH REFERRAL - 20% coinsurance (deductible does not apply) WITHOUT REFERRAL - 20% coinsurance after $600 deductible
	Out-Of-Network	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Transplant Services	In-Network	$1,500 in addition to all other copayment/coinsurance - Prior Authorization Required
	Out-Of-Network	Not Covered