



**Teachers Retirement System**

Member Benefits	Member Responsibility				
		In-Network	Out-of-Network (OON)		
<b>Plan Year Deductible</b>	<b>Medical</b>	Individual	Not Applicable	Not Applicable	
		Family	Not Applicable	Not Applicable	
	<b>Pharmacy</b>	Individual	Not Applicable	Not Applicable	
		Family	Not Applicable	Not Applicable	
<b>Plan Year Out-of-Pocket Maximum (OOPM)</b>					
<i>Combined medical &amp; pharmacy expenses including deductible, coinsurance &amp; copayments will not exceed the IRS maximum allowed.</i>		<b>Medical</b>	Individual	\$3,000	Not Applicable
			Family	\$6,000	Not Applicable
<b>Contract Year Maximum Benefits</b>					
		Cardiac Rehabilitation Services	36 OP sessions w/in 6 month of event		
		Outpatient Rehabilitation Services	60 visits per primary medical diagnosis per plan year combined PT/OT/ST		
		Habilitative Services	60 visits per primary medical diagnosis per plan year combined PT/OT/ST		
		Acupuncture Treatment	15 visits per plan year		
		Pediatric Vision Therapy	12 visits for treatment of Convergence Insufficiency per plan year		
<b>Ambulatory Patient Services</b>					
		Vision Exam	Not Covered	Not Covered	
		Virtual Visits	\$10 per visit	Not Covered	
		Primary Care Physician Office Visits	\$20 per visit	Not Covered	
		Specialty Care Physician Office Visits	\$20 per visit	Not Covered	
		Chiropractic Services	\$20 per visit	Not Covered	
		Acupuncture	\$20 per visit	Not Covered	
		Urgent Care Visits	\$20 per visit	\$20 per visit	
		Allergy Treatment and Testing	\$0 per visit	Not Covered	
<b>Emergency Services</b>					
		Emergency Department Visits	\$200 per visit	\$200 per visit	
		Emergency Ambulance Transportation	\$0 per transport	\$0 per transport	
<b>Hospital Services</b>					
		Outpatient Surgery/Procedures Facility Fee	\$150 per procedure	Not Covered	
		Outpatient Surgery/Procedures Physician/Surgeon Services	0%	Not Covered	
		Inpatient Hospitalization Facility Fees	\$250 per stay	Not Covered	
		Inpatient Physician/Surgeon Fees	0%	Not Covered	
<b>Rehabilitative and Habilitative Services</b>					
		Outpatient Rehabilitation Services	\$20 per visit	Not Covered	
		Inpatient Rehabilitation/Skilled Nursing Facility	\$0 per stay	Not Covered	
		Home Health	\$15 per visit	Not Covered	
<b>Diagnostic Services</b>					
		MRI and CT Scans	\$0 per service	Not Covered	
		Diagnostic Testing Laboratory	\$0 per service	Not Covered	
		Diagnostic Testing X-Ray	\$0 per service	Not Covered	
<b>Mental Health/Substance Use Treatment</b>					
		Outpatient Office Visits	\$20 per visit	Not Covered	
		Inpatient Services	\$250 per stay	Not Covered	
<b>Prescription Drugs</b>					
<i>30 day supply</i>					
		Reduced Generic Tier 1	\$4	Not Covered	
		Generic Tier 1	\$10	Not Covered	
		Preferred Brand - Preferred Specialty Tier 2	\$20	Not Covered	
		Non-Preferred Brand - Non-Preferred Specialty Tier 3	\$40	Not Covered	

<b>Member Benefits</b>	<b>In-Network</b>	<b>Out-of-Network (OON)</b>
<p><i>If you or your Physician requests a brand name drug when a generic drug exists, you pay the Preferred Brand or Non-Preferred Brand Deductible, Copayment and/or Coinsurance, plus a 100% coinsurance for the difference in cost between the Brand name drug and the Generic drug. This price difference is applied to your Deductible, if your plan has one. In no instance will the total cost you are charged for the drug exceed the actual cost of the drug</i></p>		

**Maternity**

*Minimum of 48 hours of inpatient care following a vaginal delivery and minimum of 96 hours of inpatient care following a delivery by Cesarean section.*

Routine Prenatal Care	\$50	Not Covered
Maternity Inpatient	\$250 per stay	Not Covered
Newborn Care	\$250 per stay	Not Covered

**Preventive and Wellness Services**

*Immunizations, adult & child annual physical exams, mammograms, PAP smears, prostate exams & more. Age/frequency schedules apply.*

Wellness Care	\$0	Not Covered
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**Other Services**

*Other services covered within your policy and not otherwise specified on this summary or on the SBC.*

Other Covered Services	0%	Not Covered
Abortion Procedure Facility Fee	\$150 per procedure	Not Covered
Abortion Procedure Physician Fee	0%	Not Covered
Durable Medical Equipment	20%	Not Covered

This is a brief statement of Health Alliance **HMO** benefits, exclusions and limitations which are subject to change. Please refer to the Health Alliance **HMO** Policy booklet for more detail about your health plan. This document is in conjunction with the Summary of Benefits and Coverage (SBC). You can view your SBC online at [www.healthalliance.org](http://www.healthalliance.org) or request a copy by contacting the customer service number on the back of your ID card.