

STATE OF ILLINOIS TEACHERS' RETIREMENT INSURANCE PROGRAM PARTICIPANTS

This overview is a summary only. It is subject to the benefits, exclusions, modifications and limitations contained in your Summary Plan Description (SPD) booklet.

BENEFIT	TIER I HMO Contracted Provider	TIER II PPO Contracted Provider	TIER III Out-of-Network Provider
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum			
Per Individual Enrollee	\$6,600 (includes eligible charges from Tier I and Tier II combined)		Unlimited
Per Family	\$13,200 (includes eligible charges from Tier I and Tier II combined)		Unlimited
Annual Plan Deductible <i>Must be satisfied for all services</i>	\$0	\$300 per Enrollee*	\$400 per Enrollee*
HOSPITAL SERVICES (May require pre-authorization. Please refer to your benefit booklet for details.)			
Inpatient	100% after \$250 copayment per admission	80% after \$300 copayment per admission	60% after \$400 copayment per admission**
Pre-Certification Penalty			\$500
Inpatient (Behavioral Health Services, Psychiatric)	100% after \$250 copayment per admission	80% after \$300 copayment per admission	60% after \$400 copayment per admission**
Inpatient (Behavioral Health Alcohol/Substance Abuse)	100% after \$250 copayment per admission	80% after \$300 copayment per admission	60% after \$400 copayment per admission**
Emergency Room <i>Waived if admitted</i>	100% after \$200 copayment per visit	100% after \$200 copayment per visit	100% after \$200 copayment per visit
Outpatient Surgery	100% after \$150 copayment per visit	80% after \$150 copayment per visit	60% after \$150 copayment per visit**
Diagnostic Lab & X-Ray			
Doctor's Office	100%	80%	60%**
Facility or Lab	100%	80%	60%**
Complex Imaging (CT/Pet Scans, MRIs)	100%	80%	60%**
PHYSICIAN AND OTHER PROFESSIONAL SERVICES (Copayment not required for preventive services.)			
Urgent Care Services	100% after \$20 copayment	80%	60%**
Physician Office Visits	100% after \$20 copayment	80%	60%**
Specialist Office Visits <i>Includes Behavioral Health providers</i>	100% after \$20 copayment	80%	60%**
Preventive Services <i>Including immunizations</i>	100%	100%, Deductible waived	Covered under Tier I and Tier II only
Well Baby Care <i>(first year of life)</i>	100%	100%, Deductible waived	Covered under Tier I and Tier II only
OTHER SERVICES			
Prescription Drugs	Prescription Drugs (30-day supply) – Covered through the plan administrator, CVS Caremark		
	Generic \$10	Preferred Brand \$20	Nonpreferred Brand \$40
Durable Medical Equipment	80%	80%	60%**
Skilled Nursing Facility <i>120 days per plan year</i>	100% with pre-certification	80% with pre-certification	Covered under Tier I and Tier II only
Transplant Coverage	100% with pre-certification	80% with pre-certification	Covered under Tier I and Tier II only
Home Health Care	100% after \$15 copayment	80%	Covered under Tier I and Tier II only
Physical Therapy and Occupational Therapy <i>60 visits per plan year</i>	100% after \$20 copayment per visit with pre-certification	80% with pre-certification	60%** with pre-certification
Speech Therapy <i>60 visits per plan year</i>	100% after \$20 copayment per visit with pre-certification	80% with pre-certification	60%** with pre-certification

Please note:

* Your out-of-pocket maximum is the most you will be required to pay for any covered expenses. Plan payments do not count toward the out-of-pocket maximum. Annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year.

** Covered services received from Tier III providers (out-of-network) are covered for "Usual & Customary" (U&C) charges – fees normally charged for comparable treatment in the same geographic area or amounts over the Medicare reimbursement schedule (MAC) for services rendered. Participating Tier I and Tier II physicians and facilities usually charge a lower, contracted rate for services. For more information on U&C, consult your Summary Plan Description (SPD) booklet.