

# TRH HDHP 2500 Individual Schedule of Benefits



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**TRH 2500 HDHP Health Utilizes The Blue Network P**

**Self-only Deductible Amounts:** Individual must satisfy the following calendar year deductibles during a benefit period:

**For Network Provider Services**

**For Out-of-Network Provider Services**

**(The network & out-of-network deductibles are separate & do not combine.)**

**Out-of-Pocket Maximums:**

Benefits will be provided at 100% for an individual during the remainder of a calendar year after the following out-of-pocket covered expenses have been incurred:

**Individual Network Provider Out-of Pocket**

**Individual Out-of Network Provider Out-of-Pocket**

<b>TRH 2500 HDHP</b>
\$2,500
\$2,500
\$3,750
Unlimited

**Coinsurance Percentages:**

The program pays the following percentages of your eligible expenses after the deductible is satisfied:

- Network Provider Services .....80%
- Out-of-Network Provider Services .....60%

**PRE-EXISTING CONDITION WAITING PERIOD**

Benefits will not be provided for any pre-existing condition until a member has completed a waiting period of at least 12 months. Pre-existing condition waiting periods may vary in duration. A pre-existing condition is defined in the Evidence of Coverage as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this EOC for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

**\$2 Million Maximum Lifetime Benefits Payable Per Member.**

**Prescription Drugs:**

Benefits are available for prescription drugs, subject to the deductible and coinsurance. Prescription home delivery service is also available for members.

**Well-Care Services:** Benefits are available subject to deductible and coinsurance, for the following services only when provided by a network provider in the provider's office as outlined in the Schedule of Benefits.

**Annual OB/GYN Exam:** Benefits will be available for one routine OB/GYN exam per calendar year. Services must be rendered by a network provider in the physician's office and billed by a network provider. **No benefit is available for routine OB/GYN exams provided by an out-of-network provider.**

**Annual Routine PSA:** Benefits will be provided for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.

**Routine Colonoscopy:** Benefits will be provided for one routine colonoscopy every four years for members age 50 and over.

*Individual (self-only) coverage has **no** maternity benefits.*

**Please note that the following is a partial listing of benefit exclusions; for a complete explanation of benefit exclusions, please refer to the Evidence of Coverage (EOC).**

**Benefits will not be provided for:**

- Services or supplies not prescribed or performed by a physician or other professional provider (as defined in the EOC definitions);
- Services or supplies which the administrator determines are not medically necessary or medically appropriate;
- Services provided before the Member's coverage begins, services deemed pre-existing during the pre-existing condition waiting period, or services after the coverage is terminated;
- A drug, device or medical treatment or procedure which is investigational (as defined in the EOC definitions);
- Any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements);
- Services or supplies furnished without cost under the laws of any government except Medicaid (TennCare<sup>sm</sup>) coverage provided by the State of Tennessee;
- Illness or injury resulting from war;
- Services for which the member is not required or legally obligated to pay;
- Services, supplies or prosthetics primarily to change or improve appearance or which are provided in order to correct or repair the results of a prior surgical procedure the primary purpose of which was to change or improve appearance, except as otherwise specified in the EOC;
- Self-treatment or services provided by any person related to the Member by blood or marriage, or any person who resides in the Member's immediate household;
- Services paid under any other group, blanket or franchise insurance coverage; any other BlueCross or BlueShield group contract, other health insurance plan, union welfare plan, or labor-management trust plan;
- Personal hygiene (including diapers, disposable under pads and incontinence pads, except as otherwise specified in the EOC) and convenience items (such as air conditioners, breast pumps, humidifiers or physical fitness equipment);
- Telephone and e-mail consultations, unless approved by the administrator; charges incurred due to failure to keep a scheduled appointment; charges to complete forms or to provide requested medical information or records; writing or calling in a prescription; depositions, testimony or court related fees; postage, shipping, mail charges or sales tax; admitting orders unless billed with in-hospital medical visits;
- Whole blood, blood components and blood derivatives which are not officially classified as drugs;
- Custodial care, such as help in walking, getting in or out of bed, or any service that could be performed by non-professional personnel;
- Routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails (including trimming), fallen arches, weak feet and chronic foot strain. Foot orthotics, shoe inserts and custom made shoes except for diabetic patients or as part of a leg brace;
- Routine physical examinations, immunizations and screening examinations, except as otherwise specified in the EOC;
- Immunizations and vaccinations, including but not limited to, flu shots, flu mist, Human Papilloma Virus (HPV) and shots for traveling outside of the United States, except as otherwise specified in the EOC.
- Services or supplies for dental care, except as otherwise specified in the EOC. Dental services include routine, restorative, prosthetic and orthodontic services;
- Eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses, except as otherwise specified in the EOC. Eye exercises and/or therapy and visual training.
- Hearing aids and examinations for prescribing or fitting of hearing aids. For the purpose of this coverage, "hearing aids" shall include any service, device or surgical procedure designed to restore or enhance the ability to hear, including, but not limited to, audient bone conductor, electromagnetic, and/or surgically implanted devices (such as cochlear implant).
- Habilitative services of any kind (services to achieve a level of functioning that the Member has never attained). Rehabilitative services including, but not limited to, hydrotherapy, educational therapy, occupational therapy, speech therapy, recreational therapy, massage therapy, craniosacral therapy, vision exercise therapy, neuromuscular reeducation, cognitive rehabilitation, nutrition therapy and acupuncture, unless otherwise specified in the EOC;
- Surgery to change sex and related services;
- Services or supplies that are designed to medically enhance a member's level of fertility in the absence of a disease state. Procedures, drugs or biologicals for, or in connection with, artificial insemination, in vitro fertilization, or any other service, supply, or drug intended to create a pregnancy.
- Services covered under Medicare, except as required by applicable state or federal law.
- Non-medical, self-care or self-help training and any related diagnostic testing or medical social services;
- Services, surgeries or supplies to detect or correct refractive errors of the eye;
- Charges in excess of the Maximum Allowable Charge for a service or supply.
- Any treatment, service or supply including, but not limited to, surgical procedures for the treatment of obesity or morbid obesity. Any treatment, service or supply arising out of the rendering of, or failure to render, treatment for obesity or morbid obesity;
- Services or expenses for treatment of illness or injury sustained in the commission of a crime or for treatment while confined in a prison, jail or other penal institution or while in the custody of any government or law enforcement entity;
- Any treatment, services or supplies required as a result of attempted suicide or an intentionally self-inflicted illness or injury whether sane or insane, including any treatment, services or supplies arising out of the rendering of, or failure to render, treatment of any such attempted suicide or self-inflicted illness or injury;
- Services or supplies for the reversal of sterilization;
- An artificial heart or any other artificial organ, or any associated expense;
- Treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido. Treatment includes prescription drugs (such as Viagra, Cialis, etc.);
- Any treatment, services or supplies required as a result of taking an illegal drug or substance;
- Genetic testing and genetic counseling;
- Services not listed in the EOC as a covered service.