

# TRH HDHP 3000 Family Schedule of Benefits



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**TRH 3000 HDHP Health Utilizes The Blue Network P**

**Family Deductible Amounts:** The family deductible can be satisfied by one or more covered family members. The family must satisfy the following calendar year deductibles during a benefit period:

**For Network Provider Services**

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

**(The network and out-of-network deductibles are separate and 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:

**Family Network Provider Out-of Pocket**

**Family Out-of Network Provider Out-of-Pocket**

<b>TRH 3000 HDHP</b>
\$3,000
\$3,000
\$6,000
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. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract 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." The pre-existing condition waiting period will not apply to members under the age of 19.

**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: Child Health Services:** Benefits are available for a member under 7 years of age for child health supervision services, to include history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunization and laboratory tests, in keeping with prevailing medical standards, subject to the following guidelines:

**Physical Examinations:**

**Under age 1:** four exams from birth to the child's first birthday

**Age 1:** two exams from the child's first birthday to the child's second birthday

**Age 2 through 6:** \*one exam per year

\*The member's birthday determines when a year begins and ends.

Exams not used during these time periods do not carry over to the next time period.

**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. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by a network provider in the physician's office and billed by the 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.

**Please note that the following is a partial listing of benefit exclusions; for a complete explanation of benefit exclusions, please refer to the contract.**

**Benefits will not be provided for:**

- Services or supplies not prescribed or performed by a physician or other professional provider (as defined in the contract definitions);
- Services or supplies which the administrator determines are not medically necessary and 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 contract 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 contract;
- 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 disposable under pads and incontinence pads, except as otherwise specified in the contract and convenience items (such as air conditioners, 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 contract;
- Services or supplies for dental care, except as otherwise specified in the contract. 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 contract. 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, aquatic therapy, hydrotherapy, educational therapy, occupational therapy, speech therapy, recreational therapy, massage therapy, fluidotherapy, craniosacral therapy, vision exercise therapy, neuromuscular reeducation, cognitive rehabilitation, nutrition therapy, dietary supplements (vitamins), and acupuncture, unless otherwise specified in the contract;
- 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 contract as a covered service.