



**TRH HDHP 1500 INDIVIDUAL
HEALTH SCHEDULE OF BENEFITS**

TRH 1500 HDHP 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**
- (These deductibles accumulate separately.)**

TRH 1500 HDHP
\$1,500
\$1,500
\$3,000
Unlimited

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**

Coinsurance Percentages:

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

- Network Provider Services80%
- Out-of-Network Provider Services60%

**\$2,000,000 MAXIMUM LIFETIME PAYABLE FOR NETWORK PROVIDER AND/OR
OUT-OF-NETWORK PROVIDER SERVICES**

Prescription Drugs:

Benefits are available for prescription drugs, subject to the Deductible and Coinsurance. Members should show their TRH ID card to a participating pharmacy in order to get the network pricing. Using an out-of-network pharmacy will decrease the amount that you are reimbursed on prescription drugs. Prescription purchases are paid by the member up front; members can then file prescription claims for any eligible reimbursement that might be available, subject to the deductible and coinsurance. Prescription Home Delivery service is also available for members. By using Prescription Home Delivery, members can enjoy the convenience of receiving many of their prescription drugs delivered right to their door and they may be able to save money.

Behavioral Health Care:

- Inpatient/Outpatient Coinsurance (Network & Out-of-Network Providers).....50%
- Inpatient/Outpatient Maximum per Benefit Period (Network & Out-of-Network Providers).....\$7,500
- Inpatient/Outpatient benefits Lifetime Maximum (Network & Out-of-Network Providers).....\$30,000

Behavioral Health Care Coinsurance does not apply toward the Self-only Out-of-Pocket Maximums.

Annual OB/GYN Exam: Benefits will be provided for one routine OB/GYN exam per calendar year (including Pap smear) when provided and billed by a Network Provider in the physician's office.

What Is Not Covered:

Benefits will not be provided for any pre-existing condition until a waiting period of at least 12 months has been completed. Pre-existing condition waiting periods may vary in duration. Please refer to the Evidence of Coverage (EOC) for a complete explanation.

Please note that the following is a partial listing of benefit exclusions. For a complete explanation of benefit exclusions, please refer to the 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)
- Services provided before the member's coverage begins, during the pre-existing condition waiting period or after this coverage is terminated
- Any work related illness or injury (unless resulting from self-employment not subject to Worker's Compensation)
- Services or supplies paid for by Medicare or Medicaid (TennCareSM) coverage provided by the State of Tennessee
- Speech, hydrotherapy, occupational, recreational, or education therapies; non-medical self-care or self-help training
- Self-treatment or services provided by any person related to a member by blood or marriage, or any person who resides in the member's immediate household
- Services for physical therapy which consist primarily in the use of exercise and physical fitness equipment
- Illness or injury resulting from war
- Services or supplies for dental care, except as specified in the EOC
- The prescription for or the fitting of hearing aids, eyeglasses or contact lenses, except as specified in the EOC
- Surgery mainly to improve appearance
- Services and supplies which are not medically necessary
- Routine or periodic examinations, immunizations and screenings, except as specified in the EOC
- Services or supplies in connection with the treatment of obesity
- Services or supplies in connection with eating disorders
- Custodial care
- Treatment, services or supplies required as a result of attempted suicide or an intentionally self-inflicted illness or injury whether sane or insane
- Surgical or medical care to modify the sex of a member
- Treatment of sexual dysfunction, including prescription drugs
- Personal hygiene and convenience items
- Investigative services or supplies
- Treatment of illness or injury sustained in the commission of a crime or while confined in a prison or jail or while in the custody of any government or law enforcement entity
- Telephone and e-mail consultations, missed appointments or charges to complete forms or to provide requested medical information or records
- Services, surgeries or supplies to detect or correct refractive errors of the eye
- Any artificial organ or any associated expenses
- Services or supplies for the reversal of sterilization
- Artificial insemination, in vitro fertilization, or any other service, supply, or drug intended to create a pregnancy or any service or supply designed to enhance the level of fertility
- Charges in excess of the maximum allowable charge

For a complete explanation of benefit exclusions, please refer to the Evidence of Coverage (EOC).