


**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**TRH Health Insurance Company: Preferred 450**

**Coverage Period: 01/01/2024 through 12/31/2024**  
**Coverage for: Individual and Family | Plan Type: PPO**



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.fbhealthplans.com/summary-of-benefits-and-coverage](http://www.fbhealthplans.com/summary-of-benefits-and-coverage) or call 1-877-874-8323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$450</b> / Individual	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	No.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other <u>deductibles</u> for specific services?</b>	No. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>\$3,600 individual / \$9,000 family.</b> Not applicable for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, ER <u>deductible</u> , <u>out-of-network coinsurance</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.fbhealthplans.com/providers">www.fbhealthplans.com/providers</a> or call 1-877-874-8323 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from the <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> or Not Covered	– Mammograms: one between ages 35 – 39 and one per calendar year for ages 40 and older.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization required for advanced radiological imaging. No coverage when prior authorization not obtained.
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.fbhealthplans.com">www.fbhealthplans.com</a>	Generic drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization requirements and quantity limitations apply to certain drugs. No coverage when prior authorization not obtained.
	Preferred brand drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Non-preferred brand drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	Emergency room care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage limited to <b>\$450</b> per trip for ground ambulance
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization required. Benefits reduced to <b>50%</b> when prior authorization not obtained.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization is required. Benefits reduced to 50% when prior authorization not obtained.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Member must have been covered on family coverage for nine consecutive months. Maternity benefits are not available on individual coverage.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 45 visits per calendar year. Prior authorization required. No coverage when prior authorization is not obtained.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Physical therapy limited to 40 visits per calendar year.</li> <li>Speech therapy for disorders of articulation and swallowing limited to 30 visits per calendar year. Prior authorization required.</li> <li>Occupational therapy for major trauma to hand limited to 30 visits per calendar year. Prior authorization required.</li> <li>Inpatient rehabilitation limited to 28 days per calendar year. Prior authorization is required. Benefits may be reduced or denied when prior authorization not obtained.</li> </ul>
	<u>Habilitation services</u>	Not covered	Not covered	None.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per calendar year. Prior authorization required. Benefits reduced to 50% when prior authorization is not obtained.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Hospice services</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Prior authorization is required. No coverage when prior authorization is not obtained.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	None.

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                                     |  |  |
|-------------------------------------|--|--|
| • Acupuncture                       | • Habilitation services                      | • Private duty nursing                   |
| • Bariatric surgery                 | • Hearing aids for adults 18 years and older | • Routine eye care (adults and children) |
| • Cosmetic surgery                  | • Infertility treatment                      | • Routine foot care                      |
| • Dental care (adults and children) | • Long term care services                    | • Weight loss programs                   |

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|---------------------|--|--|
| • Chiropractic care | • Hearing aids for children under age 18 | • Non-emergency care when traveling outside US |
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, [www.tn.gov/commerce/insurance](http://www.tn.gov/commerce/insurance) or [CIS.Complaints@state.tn.us](mailto:CIS.Complaints@state.tn.us). You may also write them at 500 James Robertson Parkway, Davy Crockett Tower, 4<sup>th</sup> Floor, Nashville, TN 37243. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, [www.tn.gov/commerce/insurance](http://www.tn.gov/commerce/insurance) or [CIS.Complaints@state.tn.us](mailto:CIS.Complaints@state.tn.us). You may also write them at 500 James Robertson Parkway, Davy Crockett Tower, 4<sup>th</sup> Floor, Nashville, TN 37243.

### Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-808-9008.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-808-9008.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-808-9008.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-808-9008.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$450
■ <u>Specialist</u> copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$450
Copayments	\$0
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$3,000</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$450
■ <u>Specialist</u> copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$450
Copayments	\$0
Coinsurance	\$1,400
What isn't covered	
Limits or exclusions	\$180
<b>The total Joe would pay is</b>	<b>\$2,030</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$450
■ <u>Specialist</u> copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,930</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$450
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$750</b>