Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
TRH Health Insurance Company: Premier 1840

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 or call 1-877-874-8323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,800** / Individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Network provider office visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$110** for each emergency room visit. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$9,000 individual / $22,500 family.** Not applicable for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments, premiums, balance-billing charges, ER deductible; out-of-network coinsurance, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.fbhealthplans.com/providers or call 1-877-874-8323 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$40** copay / office visit; deductible does not apply. **20%** coinsurance for other outpatient services.	**40%** coinsurance	Copayment does not apply to: advanced radiological imaging; maternity services; allergy testing/injections; biopsy interpretation; bone density test; cardiac diagnostic test; chemotherapy services; chiropractor services; dental services; independent lab or radiology services; DME; growth hormone injections; IV therapy; Lupron injections; mammograms; nerve conduction tests; neuropsychological or neurological tests; nuclear cardiology; nuclear medicine; orthotics; prosthetics; provider administered specialty pharmacy medication; sleep studies; surgery performed in office and related surgical supplies; Synagis injections; and ultrasounds. These services are subject to deductible and coinsurance.
	Specialist visit	**$40** copay / office visit; deductible does not apply. **20%** coinsurance for other outpatient services.	**40%** coinsurance	
	Preventive care/screening/ immunization	**$40** copay / office visit; deductible does not apply. **20%** coinsurance for other outpatient services.	**40%** coinsurance or Not Covered	– Children under age 7: limited number of visits and immunizations. No coverage for out-of-network provider services. – Members 7 years and older: preventive exam and immunizations not covered. – One routine Pap smear per calendar year. – One PSA per calendar year. – One routine OB/GYN exam per calendar year. – Mammograms: one between ages 35 – 39 and one per calendar year for ages 40 and older. – Routine colonoscopy: one every four years for members age 50 and older.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None.

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)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior authorization required for advanced radiological imaging. No coverage when prior authorization not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.fbhealthplans.com	Generic drugs	20% coinsurance	40% coinsurance	Prior authorization requirements and quantity limitations apply to certain drugs. No coverage when prior authorization not obtained.
	Preferred brand drugs	20% coinsurance	40% coinsurance	
	Non-preferred brand drugs	20% coinsurance	40% coinsurance	
	Specialty drugs	20% coinsurance	40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance / $110 ER deductible	40% coinsurance / $110 ER deductible	Emergency Room (ER) deductible is in addition to the calendar year deductible. ER deductible waived if admitted as inpatient from the emergency room.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Coverage limited to **$450** per trip for ground ambulance
	Urgent care	**$40** copay / office visit; deductible does not apply. **20%** coinsurance for other outpatient services.	**40%** coinsurance	Copayment does not apply to: advanced radiological imaging; maternity services; allergy testing/injections; biopsy interpretation; bone density test; cardiac diagnostic test; chemotherapy services; chiropractor services; dental services; independent lab or radiology services; DME; growth hormone injections; IV therapy; Lupron injections; mammograms; nerve conduction tests; neuropsychological or neurological tests; nuclear cardiology; nuclear medicine; orthotics; prosthetics; provider administered specialty pharmacy medication; sleep studies; surgery performed in office and related surgical supplies; Synagis injections; and ultrasounds. These services are subject to deductible and coinsurance.
If you have a hospital	Facility fee (e.g., hospital	20% coinsurance	40% coinsurance	Prior authorization required. Benefits reduced to

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)	
stay	room)			**50%** when prior authorization not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**$40** copay / office visit; deductible does not apply. **20%** coinsurance for other outpatient services.	40% coinsurance	Copayment does not apply to: advanced radiological imaging; maternity services; allergy testing/injections; biopsy interpretation; bone density test; cardiac diagnostic test; chemotherapy services; chiropractor services; dental services; independent lab or radiology services; DME; growth hormone injections; IV therapy; Lupron injections; mammograms; nerve conduction tests; neuropsychological or neurological tests; nuclear cardiology; nuclear medicine; orthotics; prosthetics; provider administered specialty pharmacy medication; sleep studies; surgery performed in office and related surgical supplies; Synagis injections; and ultrasounds. These services are subject to deductible and coinsurance.
	Inpatient services	20% coinsurance	40% coinsurance	Prior Authorization is required. Benefits reduced to 50% when prior authorization not obtained.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	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% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 45 visits per calendar year. Prior authorization required. No coverage when prior authorization is not obtained.
	Rehabilitation services	20% coinsurance	40% coinsurance	– Physical therapy limited to 40 visits per calendar year. – Speech therapy for disorders of articulation and swallowing limited to 30 visits per calendar year. Prior authorization required. – Occupational therapy for major trauma to hand limited to 30 visits per calendar year.

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)	
				Prior authorization required. – Inpatient rehabilitation limited to 28 days per calendar year. Prior authorization is required. Benefits may be reduced or denied when prior authorization not obtained.
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per calendar year. Prior authorization required. Benefits reduced to 50% when prior authorization is not obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance	
	Hospice services	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Prior authorization is required. No coverage when prior authorization is not obtained.
If your child needs dental or eye care	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (adults and children)
- Habilitation services
- Hearing aids for adults 18 years and older
- Infertility treatment
- Long term care services
- Private duty nursing
- Routine eye care (adults and children)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Hearing aids for children under age 18
- Non-emergency care when traveling outside US

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 or CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Parkway, Davy Crockett Tower, 4th 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 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 or CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Parkway, Davy Crockett Tower, 4th 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 deductible	**$1,800**
Specialist copayment	**$40**
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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$80
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$4,130**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,800**
Specialist copayment	**$40**
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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$320
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$180
The total Joe would pay is	**$3,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,800**
Specialist copayment	**$40**
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)*

Total Example Cost	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.