

PLAN 9 - ACO 0 Deductible



BENEFIT SUMMARY

<u>Benefit/Feature</u>	<u>Preferred Providers</u> Aetna Whole Health Tennessee*	<u>Non-Preferred Providers</u> Aetna Whole Health Tennessee*	<u>Out- of-Network Providers</u>
No Referrals Required	Maximum Savings	Standard Savings	
Deductible (Embedded*) (every Calendar year)	\$0/Individual; \$0/Family	\$2,000/Individual; \$4,000/Family	\$4,000/Individual; \$8,000/Family
Out-of-Pocket Maximum (Embedded*) (every Calendar Year)	\$3,000/Individual; \$6,000/Family	\$6,000/Individual; \$9,000/Family	Unlimited
(Out of Pocket Maximum is combined between In-Network and Out-of-Network and includes deductible, coinsurance, medical copayments and prescription copays/coinsurance , but does not include non covered amounts above the plan's fee schedule or allowable charge, or pre-authorization penalties.)			
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
PHYSICIAN SERVICES			
Office Visit to Primary Care	You pay \$25 copay/visit	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Office Visit to Specialist	You pay \$50 copay/visit	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Pre-Natal Care	You pay \$25 copay/visit (initial visit only)	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Routine Physical	Plan pays 100%	Plan pays 100%	Plan pays 50%(1) after deductible
Well Care (Child & Adult)	Plan pays 100%	Plan pays 100%	Plan pays 50%(1) after deductible
Childhood Immunizations	Plan pays 100%	Plan pays 100%	Plan pays 50%(1) after deductible
Inpatient/Outpatient Professional Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
HOSPITAL SERVICES			
Inpatient Admission ⁽²⁾	You pay \$500 copay/day for up to 5 days, then 100%	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Outpatient Services	You pay \$500 copay/visit, then 100%	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Outpatient Ambulatory Surgery ⁽²⁾			
- Physician Charges	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
- Hospital Charges	You pay \$500 copay/visit, then 100%	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
- Free-standing Surgical Center	You pay \$500 copay/visit, then 100%	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Urgent Care Center	You pay \$75 copay/visit	You pay \$75 copay/visit	You pay \$75 copay/visit
Emergency Room Services	Plan pays 80% after deductible (Out-of-Area True Emergency Admissions are subject to the Preferred Benefits)		
Inpatient Rehab & Skilled Nursing ⁽²⁾	You pay \$500 copay/day for up to 5 days, then 100% (120 days per year)	Plan pays 60% after deductible (120 days per year)	Plan pays 50%(1) after deductible (120 days per year)
OTHER SERVICES			
Outpatient Therapies ⁽²⁾	Includes Physical, Occupational & Speech All Therapies (60 visit combined limit, every plan year) (This limit does not apply to benefits associated with Autism Spectrum Disorder, developmental delays, or acquired brain injury)		
- Hospital Based	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
- Office Based	You pay \$50 copay/visit	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Laboratory Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Diagnostic Services ⁽²⁾			
- MRIs, MRAs, CT Scans, and PET Scans ⁽²⁾	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
- All Other Diagnostic Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Durable Medical Equipment ⁽²⁾	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Home Health Care ⁽²⁾	Plan pays 80% after deductible (120 visits per year/not to exceed 4 hrs per visit)	Plan pays 60% after deductible (120 visits per year/not to exceed 4 hrs per visit)	Plan pays 50%(1) after deductible (120 visits per year/not to exceed 4 hrs per visit)
Chiropractic Care <small>Covered age 18 and older only</small>	You pay \$50 copay/visit (20 visit maximum every plan year)	Plan pays 60% after deductible (20 visit maximum every plan year)	Plan pays 50%(1) after deductible (20 visit maximum every plan year)
MENTAL DISORDER & SUBSTANCE ABUSE SERVICES			
Inpatient Mental Disorder/Substance Abuse ⁽²⁾	You pay \$500 copay/day for up to 5 days, then 100%	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
Outpatient Mental Disorder/Substance Abuse ⁽²⁾			
- Hospital Based	You pay \$500 copay/visit, then 100%	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
- Office Based or Freestanding Facility	You pay \$25 copay/visit	Plan pays 60% after deductible	Plan pays 50%(1) after deductible
<p>(1) For all Out-of-Network elective and non-emergent Hospital services the Plan will not pay more than Plan's Allowable Charge which will be based on 50% of Recognized Charges for both inpatient & outpatient services.</p> <p>(2) Some of these services require pre-authorization. For Network services, your physician should obtain pre-authorization for you, however, you are ultimately responsible for pre-authorization for all services (in or out-of-network), otherwise a penalty of 50% of the Plan's allowable amount, to a maximum of \$2,500 will be applied.</p> <p>*Members must live in ACO service area to enroll in ACO Plan</p> <p>Note: This summary is not intended to be a comprehensive list of services and is not a guarantee of coverage. Once enrolled, you will be supplied with a Plan Document/Summary Plan Description (SPD) that will detail all covered services.</p> <p>*Embedded means you can satisfy the Family "Deductible" or the Family "Maximum Out-of-Pocket" with any combination of family members satisfying the amount. However, no one individual may meet more than the individual amount. In-network and out-of-network Deductibles and Out-of-Pocket Maximums are "aggregated," such that Covered Services applied to one also apply to the other.</p> <p>Note: This summary is not intended to be a comprehensive list of services and is not a guarantee of coverage. Once enrolled, you will be supplied with a Plan Document/Summary Plan Description (SPD) that will detail all covered services.</p>			