Population Science Management

Summary of Benefits and Coverage

RBP PLAN

- RBP $1,000 Diamond

Group Name: Population Science Management of Tennessee

Effective Date: June 1, 2024

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Subject to plan allowable 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, go to www.detegohealth.com or call 1-866-815-6001. 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.dol.gov/ebsa/healthreform.com or www.cciio.cms.gov	
Deductible (the amount the Covered Person pays each Plan Year for Covered Services before the Coinsurance is payable) • Individual • Family Unit (Accumulated)	 $1,000 $2,000
Coinsurance • Covered Person Pays • Plan Pays	 20% 80%
Out-Of-Pocket Limit / Plan Year • Individual • Family Unit (Accumulated)	 $7,350 $14,700
This illustration describes the plan in an easily understood manner and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan; and it is not to be considered a policy of insurance.	
All Benefits Payable Under This Plan Are Subject To The Plan Allowable.	
Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits.	
Precertification Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan. A 50% (up to $2,500) penalty will apply for not obtaining precertification.	
In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently. Day, session or visit limits for certain services shown on this summary are not applicable to Mental Health and/or Substance Use Disorders. Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the benefit period.	
Copayment(s) (copay(s)) apply to: • Physician Office • Specialist Office • Urgent Care Facility • Physical, Occupational and Speech Therapy Services • Cardiac Rehabilitation • Manipulations • Routine Vision Exam • Prenatal/Postnatal Office • Mental Health/Substance Abuse/ Autism Outpatient & Office • Prescription Drugs The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.	

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Covered Services - Illness or Injury	
Physician Office Services	
• Primary Care Physician Office Visit	$25 Copay
• Specialist Physician Office Visit	$40 Copay
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. **Specialist Physician** is a physician who is not a Primary Care Physician. **Office Visit Benefits** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy), consultations and medication checks. **Physician Office Services** include but are not limited to: office visits; X-ray; laboratory and pathology services; Allergy Testing, Injections and Serums; Supplies and/or Drugs administered during the office visit; Hearing exams or Eye exams due to Illness or Injury excluding refractions. **Other Covered Services not part of the Physician Office Services Benefit (Refer to the appropriate category for benefit information) include:** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy and Chemotherapy; Surgery and Anesthesia; Therapy and Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Mental Health and Substance Use Disorders.	
Telehealth / Virtual Care Services • Virtual Primary Care • Urgent Care • Mental Health	$0 Copay, $0 Deductible
Urgent Care Facility Services (a single copay applies to each urgent care visit)	$60 Copay
Emergency Room Services (services received in a hospital emergency room setting) • Facility • Professional Services	Deductible and Coinsurance
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance
Preventive Services	
Preventive Care / Screenings	
• Affordable Care Act (ACA) required preventive services (may by subject to limits that include, but are not limited to, age, gender, and frequency)	$0 Copay, $0 Deductible
• ACA required covered preventive services (outside of limits)	Same as any other illness
• Other covered preventive services not required by ACA	Same as any other illness
Immunizations • Adult and Child • Adult	$0 Copay, $0 Deductible

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Mental Health and/or Substance Use Disorder Services	
Inpatient Services Paid at the facility's semi-private room rate.	Deductible and Coinsurance
Outpatient Services	
• Office Services	$25 Copay
• Telehealth / Virtual Care Services	$0 Copay
Office Services include office visits; medication checks; psychological therapy and/or substance use disorder counseling; x-rays; laboratory tests; supplies and/or drugs administered during the office visit. **Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items & Services.** This includes but is not limited to: psychological evaluations; assessments; testing; physical therapy; occupational therapy; speech therapy or any other covered Mental Health and/or Substance Use Disorder services.	
Emergency Room Services (services received in a hospital emergency room setting)	Deductible and Coinsurance
• Facility	
• Professional Services	
Other Covered Services - Illness or Injury	
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance
Allergies (Testing, serum & injections)	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care)	Deductible and Coinsurance
• Ground Ambulance	
• Air Ambulance	
Autism Spectrum Disorder	
• Inpatient / Partial Hospitalization	Deductible and Coinsurance
• Outpatient / Office Visits	$25 Copay
Diabetic Services (services include, self-management education, orthopedic shoes, nutritional counseling)	DiaThrive for more details
• Supplies / Equipment	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (12 month rental or purchase, whichever is least costly).	Deductible and Coinsurance
Free Standing Facility	Plan pays 100%
• Diagnostic Services (X-ray only)	
• Laboratory Services	

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Other Covered Services - Illness or Injury *Continued 1 of 2*	
Hearing Services • Implantable Devices • Hearing Aids (benefit is for under age 18 – medical necessity required). Limited to $1,500 per hearing aid.	Deductible and Coinsurance
Home Health Care (limited to 60 days per benefit period)	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance
Oral Surgery and Dentistry Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury)	Same as any other illness
Organ Transplants	Deductible and Coinsurance
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care	
• Prenatal and Postnatal Office Visits	$25 Copay
• Maternity Services (Room and Board charges limited to semi-private room rate). (Dependent daughter pregnancy is not covered).	Deductible and Coinsurance
• Newborn care (Newborns are covered for first 30 days from date of birth).	Deductible and Coinsurance
NOTE: The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.	
Rehabilitation Services - Inpatient Facility	Deductible and Coinsurance
Rehabilitation Services	
• Cardiac rehabilitation (limit to 36 sessions per benefit period)	$40 copay
Skilled Nursing Facility (limited to 60 days per calendar year. Paid at the facility's semi-private room rate).	Deductible and Coinsurance
Sleep Studies	See ConnectDME for more details.
Therapy and Manipulations	
• Physical and occupational therapy Services, (combined limit of 20 sessions per benefit period).	$40 Copay
• Speech therapy Services (limited to 20 sessions per benefit period).	$40 Copay
• Spinal Manipulation Chiropractic treatments or adjustments (limited to 20 sessions per benefit period).	$40 Copay

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Other Covered Services - Illness or Injury (Continued 2 of 2)	
Vision Services	
• Routine Vision Exam (limited to 1 exam per covered person per benefit year.)	$40 Copay
All Other Covered Services	Deductible and Coinsurance
Prescription Drugs	
Retail - per 30 day supply	
• Preferred Generic Drugs	$10 copay
• Preferred Brand Name Drugs	$45 copay
• Non-preferred Brand Name Drugs	$85 copay
NOTE: A 90 day supply is available at an Extended Supply Network pharmacy.	
Home Delivery - per 90 day supply	
• Preferred Generic Drugs	$30 copay
• Preferred Brand Name Drugs	$90 copay
• Non-preferred Brand Name Drugs	$150 copay
Specialty Drugs	Excluded
NOTE: Excluded and not covered medications: These medications may be separately available through our ancillary company, ScriptAide, using either their Patient Assistance Program (PAP), Personal Importation Program (PIP) or Self-Pay Importation Program (SPIP).	

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MONTHLY CONTRIBUTIONS

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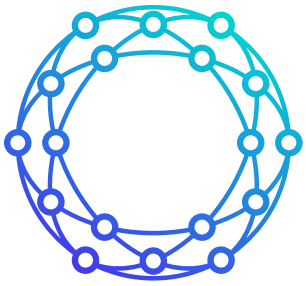
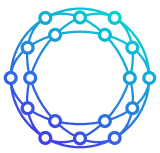
	AGES 18-29	AGES 30-44	AGES 45-54	AGES 55-64
Employee	$794.78	$820.64	$857.89	$950.20
Employee + Spouse	$1,451.35	$1,503.08	$1,572.60	$1,762.20
Employee + Child(ren)	$1,322.05	$1,368.60	$1,431.67	$1,601.80
Family	$2,112.96	$2,190.56	$2,292.33	$2,579.22





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