aetna®

Green Dot Public Schools National
Effective Date: 07-01-2018
HMO - Tennessee

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	None Individual None Family
Out-of-Pocket Maximum (per calendar year)	$1,500 Individual $4,500 Family
In-Network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%
Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%
Routine Eye Exams 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay

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Specialist Office Visits	$20 copay
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$10 copay
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	Covered 100%
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic X-ray	Covered 100%
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic X-ray for Complex Imaging Services	Covered 100%
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$10 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$100 copay
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100% for Physician maternity services; $100 copay for Facility Services
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	$50 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%

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SUBSTANCE ABUSE	IN-NETWORK
Inpatient	$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	$100 copay
Substance Abuse Office Visits	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	$100 copay
Limited to 100 days; per calendar year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%
Limited to 120 visits; per calendar year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Short-Term Rehabilitation	Covered 100%
Limited to 60 visits; per calendar year Includes Speech, Physical, and Occupational Therapy	
Chiropractic Coverage	Covered 100%
Direct access to participating providers without a referral.	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	Covered 100%
Autism Occupational Therapy	Covered 100%
Autism Speech Therapy	Covered 100%
Durable Medical Equipment	Covered 100%
Prosthetics	Covered 100%
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Affordable Care Act mandated Women's Contraceptives	Covered 100%
Hearing Aids	20%
1 hearing aid per ear to a maximum of $1,000 per ear every 3 years for covered dependents under age 18.	
Transplants	$100 copay Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	

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FAMILY PLANNING	IN-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.	
Comprehensive Infertility Services	Not Covered
Artificial insemination and ovulation induction	
Advanced Reproductive Technology (ART)	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary
Preferred Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	$20 copay
Mail Order	$40 copay
Non-Preferred Generic and Brand-Name Drugs	
Retail	$35 copay
Mail Order	$70 copay
Value Plus Specialty Drugs	
Preferred Specialty	20% Maximum $150
Non-Preferred Specialty	20% Maximum $150
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. Must use Aetna Specialty on the first fill and must use Aetna Specialty for Specialty drugs.
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Performance Enhancing Drugs limited to 4 tablets per month. Oral fertility drugs included. Oral chemotherapy drugs covered 100% Value Plus Pre-certification included Value Plus Step Therapy included One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

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Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits plans contain exclusions and limitations.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.