innovation HEALTH 2024 VA Innovation Health Silver 3: HMO + Pediatric Dental

Coverage for: Individual + Family | Plan Type: HMO

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, https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0767410&Y=24, or by calling 1-844-365-7375. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-844-365-7375 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $6,400 / Family $12,800.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain office visits, preventive care, emergency care and urgent care in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $9,200 / Family $18,400.	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?	Premiums 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 https://aet.na/providersearch_innovationhealth or call 1-844-365-7375 for a list of in-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 a 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		In-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	$35 copay/visit, deductible does not apply	Not covered	No charge for in-network virtual primary care telemedicine provider visits for certain services.
	Specialist visit	$70 copay/visit, deductible does not apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $55 copay/visit, deductible does not apply; X-ray: $25 copay/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://aet.na/vaivl24	Preferred generic drugs	Tier 1A: $5 copay/ prescription for up to a 30 day supply, $12.50 copay/ prescription for up to a 90 day supply; Tier 1: $25 copay/ prescription for up to a 30 day supply, $62.50 copay/ prescription for up to a 90 day supply, deductible does not apply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	$55 copay/ prescription for up to a 30 day supply, $137.50 copay/ prescription for up to a 90 day supply, deductible does not apply	Not covered	
	Non-preferred generic/brand drugs	40% coinsurance for up to a 90 day supply	Not covered	
	Preferred/non-preferred specialty drugs	50% coinsurance for up to a 30 day supply	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
				include access to CVS retail pharmacies for certain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance for hospital facility; 20% coinsurance for free standing facility	Not covered	None
	Physician/surgeon fees	40% coinsurance for hospital facility; 20% coinsurance for free standing facility	Not covered	None
If you need immediate medical attention	Emergency room care	$750 copay/visit, deductible does not apply	$750 copay/visit, deductible does not apply	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	$750 copay/trip, deductible does not apply	$750 copay/trip, deductible does not apply	Out-of-network cost-share same as in-network.
	Urgent care	$50 copay/visit, deductible does not apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	None
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: $35 copay/visit, deductible does not apply; All other outpatient services: 40% coinsurance	Not covered	None
	Inpatient services	40% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$70 copay/visit, deductible does not apply	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	$70 copay/visit, deductible does not apply	Not covered	Coverage is limited to 30 visits for Physical Therapy and Occupational Therapy combined, 30 visits for Speech Therapy.
	Habilitation services	40% coinsurance	Not covered	None
	Skilled nursing care	40% coinsurance	Not covered	Coverage is limited to 100 days per admission.
	Durable medical equipment	50% coinsurance	Not covered	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	40% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	$10 copay/visit, deductible does not apply	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.
	Children's glasses	$10 copay/visit, deductible does not apply	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months up to age 19.
	Children's dental check-up	0% coinsurance	Not covered	Coverage is limited 2 visits every 12 months up to age 19.

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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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 - Coverage is limited to 30 visits.
- Hearing aids - Coverage is limited to one hearing aid per ear every 24 months up to $1,500 per hearing aid for ages 0-18.
- Private-duty nursing - Coverage is limited to 16 hours.

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:

State Corporation Commission, Virginia Bureau of Insurance, 1-877-310-6560, https://scc.virginia.gov/pages/Insurance.

- For more information on your rights to continue coverage, contact the plan at 1-844-365-7375.

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 or state health insurance marketplace or SHOP.

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 on how 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:

- State Corporation Commission, Virginia Bureau of Insurance, 1-877-310-6560, https://scc.virginia.gov/pages/Insurance.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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.

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	$6,400
Specialist copayment	$70
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$6,400
Copayments	$200
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,260**

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

The plan's overall deductible	$6,400
Specialist copayment	$70
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$6,400
Specialist copayment	$70
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-365-7375.

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7375.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Innovation Health complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

For language assistance in your language call 1-844-365-7375 at no cost.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-844-365-7375.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-365-7375 ይደውሉ::
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-844-365-7375
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-844-365-7375 հեռախոսահամարով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7375 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-365-7375.
Bengali-Bangala -	আপনাকে বনিামূকযে ভাষা পবকিষা পপকে হকয এই নম্বকি পবেযক ান রেুন: 1−844−365−7375।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-365-7375.
Burmese -	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-844-365-7375 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-365-7375.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-844-365-7375.
Cherokee -	ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏣᎾᏓᏛᏁᏗ Ꮭ ᎠᎱᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᏱᏍᎩ, ᏫᎦᎯᏏᎳᏛᏏ 1-844-365-7375.
Chinese -	如欲使用免費語言服務，請致電 1-844-365-7375。
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-365-7375.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-365-7375.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-844-365-7375.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-844-365-7375.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-844-365-7375.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-365-7375 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-365-7375.

Gujarati -	તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવિઓની પહોંર્ માટે, કોલ કરો 1-844-365-7375.
Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-844-365-7375 Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-844-365-7375 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-844-365-7375.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-844-365-7375.
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-844-365-7375.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-844-365-7375.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-844-365-7375.
Japanese -	言語サービスを無料でご利用いただくには、1-844-365-7375 までお電話ください
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပ္ၤလၢကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ဘၣ်န့ၣ် ကိး 1-844-365-7375 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-844-365-7375 번으로 전화해 주십시오.
Kru-Bassa -	M̀ dyi wuḍu-dù kà kò ḍò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ḍá nɔ̀ɓà nìà kɛ: 1-844-365-7375.
Kurdish -	1-844-365-7375 بۆ دەسپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-844-365-7375.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-844-365-7375 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-844-365-7375.
Micronesian Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-365-7375.
Mon-Khmer Cambodian -	ដ ើម្បីទទួលបានដសវាកម្មភាសាដ លឥតគិតថ្លៃសម្រាប់ដោកអ្នក ូ ម្ដ ៅទូរស័ព្ទដ ៅកាន់ដលខ 1-844-365-7375។.
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojį' hólne' 1-844-365-7375.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गनन 1-844-365-7375 मा टेलिफोन गनुनहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-844-365-7375.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-844-365-7375.

Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-844-365-7375.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-844-365-7375 تماس بگیرید
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-844-365-7375.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-844-365-7375.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਬਮਿੇ ਿਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-844-365-7375 'ਤੇ ਫ਼ੋਨ ਰਿ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-844-365-7375.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-844-365-7375.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-844-365-7375.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-844-365-7375.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-844-365-7375.
Sudanic-Fulfulde -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-844-365-7375.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-844-365-7375.
Syriac -	[illegible] 1-844-365-7375 .
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-844-365-7375.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-844-365-7375 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-844-365-7375.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-844-365-7375.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-844-365-7375.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-844-365-7375 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-844-365-7375.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے 1-844-365-7375 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-844-365-7375.
Yiddish -	צו צוטריט ךארפש באדַינונגען אין קיין פרייַז צו איר, רופן 1-844-365-7375
Yoruba -	Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-844-365-7375.