

: VA IH Gold \$15 Copay 1450 HMO

Coverage for: Individual + Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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=0756343&Y=22, or by calling 1-844-365-7375. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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- <u>network</u> : Individual \$1,450 / Family \$2,900.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain office visits, <u>preventive care</u> and <u>urgent</u> <u>care</u> in- <u>network</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>network</u> : Individual \$8,700 / Family \$17,400.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://aet.na/providersearch_innovationhealth or call 1-844-365-7375 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$15 copay/visit, deductible does not apply	Not covered	None
If you visit a health care	<u>Specialist</u> visit	\$35 copay/visit, deductible does not apply	Not covered	None
provider's office or clinic	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
n you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
	Preferred generic drugs	\$10 copay/ prescription for up to a 30 day supply, \$25 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
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Preferred brand drugs	\$40 copay/ prescription for up to a 30 day supply, \$100 copay/ prescription for up to a 90 day supply	Not covered	difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network.
http://aet.na/vaihivl	Non-preferred generic/brand drugs	40% coinsurance for up to a 90 day supply	Not covered	
	Preferred <u>Specialty drugs</u> , Non-preferred <u>Specialty drugs</u>	50% coinsurance for up to a 30 day supply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> .
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
hospital stay	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$15 copay/visit, deductible does not apply; All other outpatient services: 20% coinsurance	Not covered	None
Substance abase services	Inpatient services	20% coinsurance	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery facility services	20% coinsurance	Not covered	(i.e. ultrasound).
	Home health care	20% coinsurance	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	20% coinsurance	Not covered	Coverage is limited to 30 visits for Physical Therapy and Occupational Therapy combined, 30 visits for Speech Therapy.
If you need help recovering or have other	Habilitation services	20% coinsurance	Not covered	None
special health needs	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 100 days per admission.
	Durable medical equipment	40% coinsurance	Not covered	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	Not covered	None

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Children's eye exam	50% coinsurance	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.	
If your child needs dent or eye care	Children's glasses	50% coinsurance	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	Not covered	Not covered	Not covered.	

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids

- 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 <u>plan</u> document.)

- Acupuncture Coverage is limited to 10 visits.
- Private-duty nursing Coverage is limited to 16
- Chiropractic care Coverage is limited to 30 visits.

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: Virginia State Corporation Commission, Bureau of Insurance – SCC, 800-552-7945 (Virginia only), 804-371-9741, 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete

information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

• Virginia State Corporation Commission, Bureau of Insurance – SCC, 800-552-7945 (Virginia only), 804-371-9741, 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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$1,450
Specialist copayment	\$35
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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,450	
<u>Copayments</u>	\$10	
<u>Coinsurance</u>	\$2,000	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,520	

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,450
Specialist copayment	\$35
Hospital (facility) coinsurance	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,450	
<u>Copayments</u>	\$900	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions \$2		
The total Joe would pay is	\$2,370	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$1,450
Specialist copayment	\$35
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	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,450	
<u>Copayments</u>	\$80	
<u>Coinsurance</u>	\$200	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,730	

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

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).

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TTY: 711

Language Assistance:

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

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-844-365-7375.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-844-365-7375 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7375-365-4-1-8-1

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7375 առանց գնով։

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7375 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-844-365-7375 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্য(1-844-365-7375-ত(কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7375 nga walay bayad.

Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-844-365-7375 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-844-365-7375.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-844-365-7375 sin gåstu.

Chinese - 欲取得繁體中文語言協助,請撥打 1-844-365-7375,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-844-365-7375.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-365-7375 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7375.

French - Pour une assistance linguistique en français appeler le 1-844-365-7375 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7375 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-365-7375 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7375 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-844-365-7375 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-844-365-7375. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-844-365-7375 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7375.

lbo - Maka enyemaka asusu na Igbo kpoo 1-844-365-7375 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7375 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-365-7375.

Japanese - 日本語で援助をご希望の方は、1-844-365-7375 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတိာကျိန်အင်္ဂ ကျိန် ကိုး 1-844-365-7375 လာတအိန်ဒီးတာ်လာ၁်ဘူန်လာ၁်စုးသာ

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7375 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-844-365-7375

برای راهنمایی به زبان فارسی با شماره 7375-365-444-1 به خورایی پهیومندی بکهن. - Kurdish

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7375 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शूल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-844-365-7375 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-844-365-7375 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7375 ni sohte isais.

Mon-Khmer, សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-844-365-7375 ដោយឥតគិតថ្លប់។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-844-365-7375

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-844-365-7375 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-844-365-7375 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-844-365-7375 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵੀੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7375 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-844-365-7375 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 7375-365-844 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-365-7375.

Portuguese - Para obter assistência linguística em português ligue para o 1-844-365-7375 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-844-365-7375

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-365-7375.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-844-365-7375 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-844-365-7375.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-844-365-7375.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-844-365-7375 Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-365-7375 bila malipo.

Syriac - R - 22 K & D2.31 abx - 22 K oai, or by ispor 361, so 1-844-365-7375 ap. .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7375 nang walang bayad.

Telugu - భషతో నయంకొరకు ఎలంటి ఖర్చు లేకుండా 1-844-365-7375 కు శల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-844-365-7375 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-844-365-7375 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-844-365-7375 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-844-365-7375.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7375.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 7375-365-1-844. پر بات کریں

Vietnamese - Đê 'được hố 'trợ ngôn ngư băng (ngôn ngư), hay gọi miến phi 'đên số '1-844-365-7375.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-844-365-7375 פריי פון אפצאל

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-844-365-7375 lái san owó kankan rárá.