aetna Commonwealth of Virginia: COVA HealthAware

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2015 - 06/30/2016
Coverage for: Individual + Family | **Plan Type :** POS
Aetna Health Fund® Aetna Choice® POS II

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.dhrm.virginia.gov or by calling 1-888-642-4414. You may also select, at an extra cost to you, additional options that offer enhanced coverage for dental and vision services.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Plan Year, In-network: Individual **$1,500** / Family **$3,000**; Out-of-network: Individual **$3,000** / Family **$6,000**;	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (July 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, In-network: Individual **$3,000** / Family **$6,000**; Out-of-network: Individual **$6,000** / Family **$12,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and balance-billed charges, services and supplies not covered by the plan, and out-of-pocket costs for dental and vision.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.aetna.com or call 1-855-414-1901.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded service s**.

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Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Includes Internist, General Physician, Family Practitioner and Pediatrician. PCP election not required.
	Specialist visit	20% coinsurance	40% coinsurance	——— None ———
	Other practitioner office visit	20% coinsurance	40% coinsurance	Coverage is limited to 30 visits per plan year for Chiropractic care.
	Preventive care /screening /immunization	No charge	40% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——— None ———
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——— None ———

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	20% coinsurance / prescription (retail & mail order)	40% coinsurance (retail)	Covers up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, Pre-cert and Step Therapy Apply with 90 day TOC. No charge for generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	20% coinsurance / prescription (retail & mail order)	40% coinsurance (retail)	
	Non-preferred brand drugs	20% coinsurance / prescription (retail & mail order)	40% coinsurance (retail)	
	Specialty drugs	20% coinsurance / prescription (retail & mail order)	40% coinsurance (retail)	——— None ———
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——— None ———
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——— None ———
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——— None ———
	Emergency medical transportation	20% coinsurance	20% coinsurance	No coverage for non-emergency use.
	Urgent care	20% coinsurance	40% coinsurance	——— None ———
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	——— None ———
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——— None ———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	——— None ———
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	——— None ———
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	——— None ———
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	——— None ———

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance	——— None ———
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	——— None ———
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 90 visits every plan year.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	Age limitations may apply.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 180 days per confinement. Separated by 90 days, a new allotment allowed. If not separated by 90 days subject to prior limit.
	Durable medical equipment	20% coinsurance	40% coinsurance	——— None ———
	Hospice service	20% coinsurance	40% coinsurance	——— None ———
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage is limited to 1 routine eye exam every plan year.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	No charge	No charge	Coverage is limited to 2 routine dental exams every plan year.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture (except as an alternative to anesthesia by a licensed provider)
- Cosmetic surgery
- Hearing aids
- Long-term care
- Glasses
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care - Coverage is limited to 30 visits per plan year.
  Dental coverage - Coverage is limited to 2 routine dental exams every plan year.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.
- Emergency and non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per plan year.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-642-4414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file an **appeal**. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage**.

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Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-370-4526.

如果需要中文的帮助，请拨打这个号码 1-800-370-4526.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-4526.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-4526.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

on't use these examples to imate your actual costs der this plan. The actual e you receive will be ferent from these mples, and the cost of t care also will be ferent.

e the next page for portant information about se examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,150
- **Patient pays:** $2,390

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventative	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$740
Limits or exclusions	$150
Total	**$2,390**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,070
- **Patient pays:** $2,330

Sample care costs:

Prescriptions	$2,900
Medical equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventative	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$750
Limits or exclusions	$80
Total	**$2,330**

Note: Your plan may have both **copays** and **coinsurance** for covered services; if so, these examples use **copays** only. Your costs may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.