innovation HEALTH℠
Aetna | Inova PARTNERSHIP

Together. Better Health.

Take charge of your health

Choose Innovation Health, choose affordable coverage

The information you need to choose quality and affordable health benefits and insurance coverage.

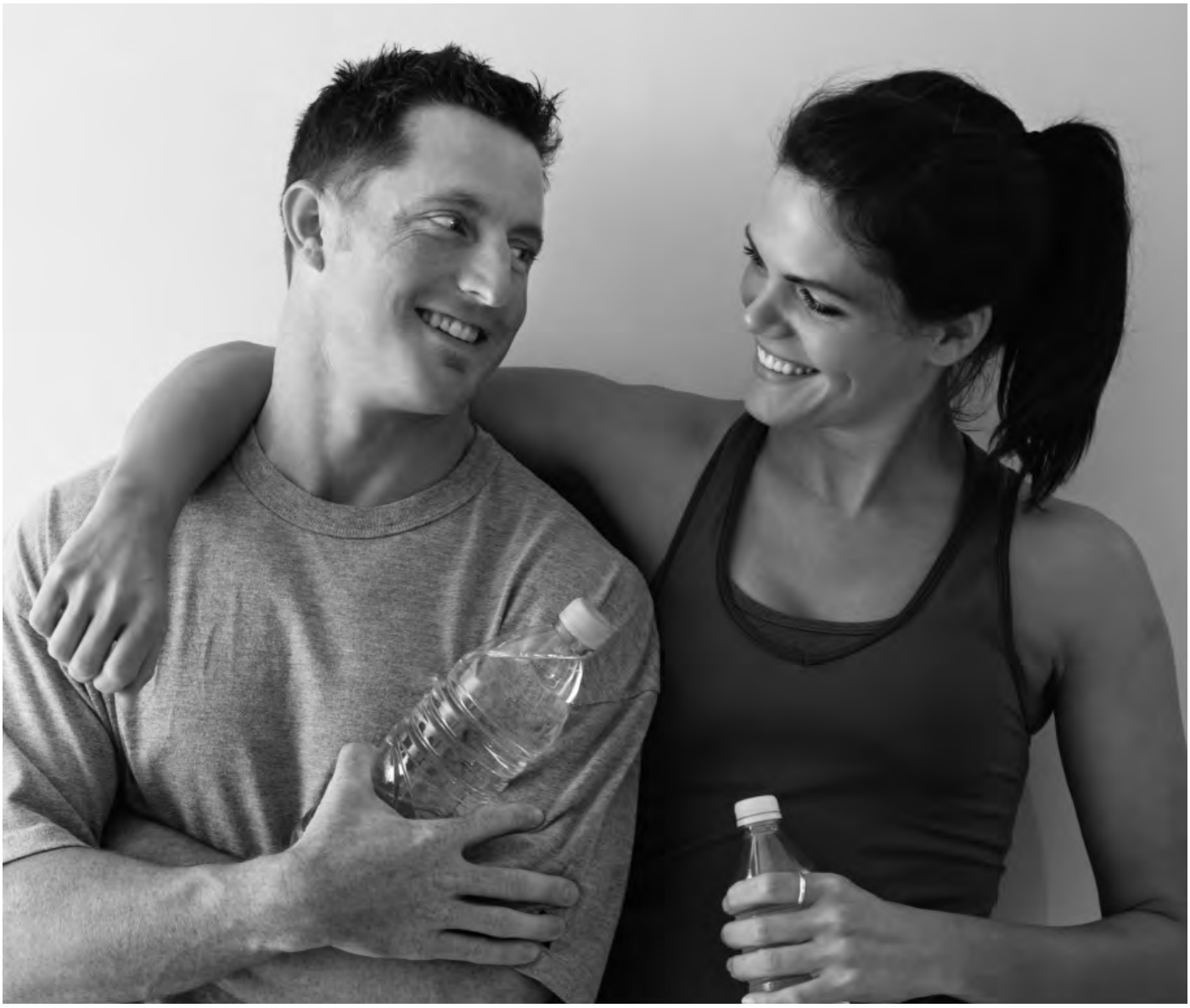
71.43.300.1 (1/14)

http://www.innovation-health.com

First things first. Is my doctor covered?

We believe a healthier experience begins with what matters most to you. And we have helpful tools like our online provider directory to help you find your doctor or hospital.

Just visit **http://www.innovation-health.com/individuals-families** to find the doctors and hospitals you trust most.



Thank you for your interest in Innovation Health

We know how important it is for you to make the right choice. This packet contains helpful tools and important tips to consider along the way. Or, if you prefer, you can call us.

We're here to help

Call **1-855-330-4546 (TTY:711).**
We're available 8 a.m. to 8 p.m. ET, Monday through Friday.

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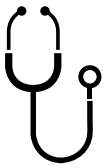
Shouldn't your plan give YOU the advantage?

Your care is important to us. We know there are few things more important than making the best choice for your health coverage.

We want you to have a positive health care experience. So let's get started with what matters most:



Your doctors

Our goal is to provide you with quality health care at an affordable price. And we have tools to help you find your doctor (or a new doctor in your area) who will help you get the most out of your benefits.

Your prescriptions

All of our plans combine prescription drug coverage and medical care.

Your way

Good news – your way begins with choice. We have plans to meet your needs and offer you more control over how you manage your health: whether by phone, online, in print or in person.

For 2014 benefits, the open enrollment period is October 1, 2013 through March 31, 2014. If you miss this window, you must wait until the next open enrollment period, unless you qualify for an exception.

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What does that mean?

Here are a few definitions of terms you'll see throughout this brochure.

Coinsurance

The portion of the cost of covered medical services you pay under a health plan, after first meeting any applicable plan deductible.

Copayment

A set dollar amount or portion that you pay for your medical services. Usually, copays start after you first pay any plan deductible. Copays may differ by type of service.

Deductible

A set amount that you must pay for your medical services before the health plan starts to pay.

Exclusions and limitations

Specific conditions or circumstances that aren't covered under a plan.

Out-of-pocket maximum

The limit on the amount an individual is required to pay for health care services that his/her benefits plan covers.

Premiums

The amount a health insurer charges for a health insurance policy. If you have a health plan through your employer, you and your employer may share this cost. If you buy a health plan yourself, you pay the full amount.

Pre-existing condition

A condition, disability or illness (physical or mental) that you had before you signed up for a health plan.

It’s easy to enroll

Many people have never had to shop for health insurance. An employer often provides it. But if you have to buy health insurance on your own, it’s important to understand the process. Once you choose your plan, select the enrollment method that works best for you.

Broker

You have an ally in the process. Get personalized assistance from your broker, who can answer your questions, help you choose the plan that’s right for you and guide you through the enrollment process.

Online

Go to **http://www.innovation-health.com/individuals-families/** for easy ways to find the plan that is best for you.

By mail

Complete and return the enclosed enrollment form.

By phone

Call us toll-free at **1-855-330-4546 (TTY: 711).**
We’re available from 8 a.m. to 8 p.m. ET, Monday through Friday.

We can also help you complete the application.

What happens next?

After you enroll, you can use this checklist to keep track of your new plan.

Material name	Description	Delivery
Welcome	This welcome letter will let you know when to expect your member ID card and plan documents. We'll also tell you how to register for the Plan Benefits Navigator℠ member website powered by Aetna Navigator®, access the Aetna Discount Program* and other helpful tips.	
Doctor visit	See your doctor to take advantage of the annual health care services available to you.	
Plan documents (Certificate of Coverage, etc.)	Think of this as your owner's manual. It includes important information about how to use your plan, what's covered and how benefits are paid. It also tells you who to call if you have questions.	

Questions?

Call us toll-free at **1-855-330-4546 (TTY: 711).**

We're available from 8 a.m. to 8 p.m. ET, Monday through Friday. Or visit us at **http://www.innovation-health.com/individuals-families/**

* Discount offers are made available by Aetna Life Insurance Company. Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. The member is responsible for the full cost of the discounted services. Aetna may receive a percentage of the fee paid to a discount vendor.

Top reasons to choose Innovation Health

Access to leading doctors and hospitals in your area

We offer health insurance plans with valuable features, which include an excellent combination of quality coverage and competitively priced premiums. Most plans also include:

- The freedom to see doctors whenever you need to – without referrals
- Coverage for preventive care, prescription drugs, doctor visits, hospitalization and immunizations
- No copayments for preventive care when you visit a network provider
- No claim forms to fill out when you use a network provider

Our goal is to provide you with quality health care at an affordable price. And we have tools to help you find your doctor (or a new doctor in your area) that will help you get the most out of your benefits.

Walk-in clinics

These health care clinics are located in retail stores, supermarkets and pharmacies. They treat uncomplicated, minor illnesses. They also provide preventive health care services. Walk-in clinics (or convenient care clinics) are often open nights, weekends and holidays when you can't see your regular provider.

E-visits

These are electronic visits between you and your health care providers. You can send a medical concern to them, and they can securely give you medical advice and/or care. They can also prescribe medication/therapy online.

Family coverage

Apply for coverage for yourself, for you and your spouse, or for your whole family.

Tax advantages with health savings accounts (HSAs)

It's easy…you set up a personal account that lets you pay for qualified medical expenses. Then, you or an eligible family member makes contributions, and that money earns interest. All contributions and withdrawals for qualifying expenses are tax free, so you pay less.

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Get more from your plan

Visit your secure member website at **http://www.innovation-health.com** and click the "Health Programs" tab to check out the Discount Program. It offers you savings on fitness, weight management, books, vision, hearing and so much more.*

You want to look and feel your best for many years to come. So give yourself a healthy advantage and use discounts available to you through our plans.

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Health care reform — What you need to know

Since President Obama signed the Affordable Care Act (ACA), we have periodically updated the Innovation Health Plans for Individuals, Families and the Self-Employed to include any necessary changes.

Be assured–your Innovation Health Plan will always meet the federal health care reform legislation requirements.

Gear up for 2014—it's an important year

In 2014, major parts of the law will be put into place, and your own coverage may be affected. The ACA will bring more, required benefits to all new health plans.

Quick facts about health care reform

- Beginning in 2014, most people must have insurance or potentially pay a penalty
- Preventive care (including immunizations) provided without cost share, including enhanced coverage of women's preventive health benefits
- Coverage will include Essential Health Benefits
- No annual or lifetime limits on Essential Health Benefits
- No pre-existing condition exclusions
- Only four criteria determine rates you pay
- Young adults up to age 26 can stay on parents' plan

Learn more about health care reform

Visit ▸ http://www.innovation-health.com/health-care-reform

Innovation Health —
A whole new way of looking at health care

Your care. Your choice.

There are many choices in health care. Sometimes it's hard to know the best option for you and your family. But it's important to know that you have the power to choose and make decisions about your care.

Innovation Health is the result of a unique partnership between Aetna and Inova, a not-for-profit health care system, designed to offer a health plan that supports you with convenient, quality health care.

Health plans are offered in Northern Virginia including: Alexandria City, Arlington County, Fairfax County, Fairfax City, Falls Church City, and Loudoun County.

Better access. Better care. Better outcomes.

The Aetna and Inova partnership combines longstanding local, regional and national experience to help improve the quality of your health care while giving you access to the leading doctors and hospitals in your area.

The Innovation Health network includes:

- five hospitals*
- more than 3,700 physicians and more than 80 ambulatory care sites
- 55 outpatient centers, with five hospital-based ERs, four stand-alone emergency care centers, four urgent care centers and 11 outpatient physical therapy centers

What's different?

- You have a team of doctors — rather than a single practitioner — to manage conditions such as diabetes, asthma or high blood pressure.
- You benefit from a greater emphasis on:
  - Wellness programs to keep you healthy and productive
  - Preventive care such as cancer screenings and flu shots
  - Coaching and supportive services to help you better follow treatment plans
- You are treated in a holistic manner with access to quality health care and services delivered to you in a more tailored and personalized way.

Choosing your doctors

We know that finding the right doctor is important to you and your family. And, to get the most out of your plan and save the most money, you'll need to choose doctors and facilities that are part of the Innovation Health network.

Visit our website at **http://www.innovation-health.com** and click on "Find a Doctor" to access our online directory. Select your plan from the drop down menu.

Keep in mind that you may use doctors and hospitals outside of the Innovation Health network, but they will be out of network. Check your plan documents to understand your costs if you use out-of-network providers.

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*Inova includes five hospitals: Alexandria Hospital in Alexandria; Mount Vernon Hospital in Alexandria; Fairfax Hospital in Falls Church; Hospital for Children in Falls Church; Fair Oaks Hospital in Fairfax. Inova's hospitals have been recognized by U.S. News & World Report as Best Hospitals for 2013-14.

Use our online tools

You can compare costs for many health care services. You can also see the cost-savings of being an Innovation Health network member. When you know costs, you can make the most out of your benefits. This can help you save by:

- Seeing what you'll pay for doctor and hospital services based on your actual health benefits and insurance plan.
- Compare estimates for up to 10 doctors or hospitals at a time.*
- Compare in- and out-of-network cost estimates for office visits, surgeries, medical tests and more.
- Look up costs for prescription drugs —before you fill a prescription. And find out what you can save by using our home delivery service.

Questions?

To find out more about Innovation Health and how you can improve your health while lowering your health care costs visit **http://www.innovation-health.com** or call **1-855-228-0510**.

* Estimated costs not available in all markets. Actual costs may differ for a number of reasons, including if other or different services are performed by the doctor or facility at the time of your visit, and/or additional claims/member payments are processed before the actual claim for the estimated service is processed.

Save money — use our provider network

Maybe you've read that one of the best ways to save on health care costs is to "stay in network." But you're not sure what that means.

You're not alone. Many people find the term confusing. We're here to help you understand what in network means for you.

How our network helps you save

A network is a group of health care providers. It includes doctors, specialists, dentists, hospitals and other facilities. These health care providers have a contract with us. As part of the contract, they provide services to our members at a lower rate.

This contract rate is usually much lower than what the doctor would charge if you were not an Innovation Health member. And the network doctor agrees to accept the contract rate as payment. You pay your coinsurance or copay, along with your deductible, if applicable.

So what does this all mean? It means you have access to the care you need at a lower price. And the difference in cost can be huge — for the same type of service or procedure.

How much you can save

Some of our plans pay for services if you see a doctor who is not in our network. Many of those plans pay for out-of-network services based on what is called the Medicare Rate Schedule. The government maintains and determines Medicare rates. Innovation Health plans base their payment on a percentage of Medicare's. How much may depend on exactly what plan you pick.

You can see how we figure out that charge in the chart on the next page.

Find doctors and hospitals in the network

It's easy to look up in network doctors and hospitals using our Innovation Health Custom DocFind® directory. It's a good idea to check every time you make an appointment.

Visit **http://www.innovation-health.com/individuals-families/** and select "Find a Doctor," or call **1-855-330-4546 (TTY:711)** and ask for provider information.

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Example: Innovation Health member, Lee
(For illustrative purposes only. Does not reflect events experienced by an actual participant.)

		In Network	Out of Network
Doctor bill	This is the charge from the doctor.	$825	$825
Contract/Allowed amount	**In network:** This is the amount a doctor has agreed to accept with Innovation Health. In this example, Innovation Health gets you a $325 discount off the doctor's bill.	$500	
	Out of network: This is the maximum amount Innovation Health will pay an out-of-network doctor based on the Medicare Rate Schedule.		$400
Deductible	Lee's plan has two types of deductibles:	$50	$100
	In network: Lee pays the first $50 of her costs. Contract amount: $500 Deductible: - $50 Amount after deductible: $450		
	Out of network: Lee pays the first $100 of her costs. Allowed amount: $400 Deductible: - $100 Amount after deductible: $300		
Plan coinsurance	Lee's plan has two types of coinsurance:	$90	$120
	In network: Lee pays 20% of the contract amount after her deductible. Amount after deductible: $450 Amount after deductible ($450) x 20% = coninsurance amount: $90		
	Out of network: Lee pays 40% of the allowed amount after her deductible. Amount after deductible: $300 Amount after deductible ($300) x 40% = coninsurance amount: $120		
	Innovation Health plan pays	$360	$180
	Lee pays	**$140**	**$645**

Costs for out-of-network doctors and hospitals

People are paying more of their health care costs these days. It's no wonder there is a lot of interest in keeping these costs down.

A smart way to do this is to avoid using doctors and hospitals that are "out of network." We do not have a contract for reduced rates with an out-of-network doctor or hospital. So you could end up with higher costs and more work.

Why out-of-network costs more

There are a few reasons you probably will pay more out of pocket:

- Your Innovation Health health benefits or insurance plan may pay part of the doctor's bill. But it pays less of the bill than if you get care from a network doctor.
- Some plans may not pay any benefits if you go out of network. Some plans cover out of network only in an emergency.

Cost sharing is more

With most plans, your coinsurance is higher for out-of-network care. Coinsurance is the part of the covered service you pay for. (For example, the plan pays 80 percent of the covered amount, and you pay 20 percent coinsurance.)

Out-of-network rates are higher

- An out-of-network doctor sets the rate to charge you. It is usually higher than the amount your Innovation Health plan "recognizes" or "allows."
- An out-of-network doctor can bill you for anything over the amount that Innovation Health recognizes or allows. This is called "balance billing." A network doctor has agreed not to do that.
- We do not base our payments on what the out-of-network doctor bills you. We do not know in advance what the doctor will charge.

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Deductibles are separate, higher

- What you pay when you are balance billed does not count toward your deductible. And it is not part of any cap your plan has on how much you have to pay for covered services.
- Many plans have a separate out-of-network deductible. This is usually higher than your in-network deductible. (Sometimes, you have no deductible at all for care in the network.) You must meet the out-of-network deductible before your plan pays any out-of-network benefits.

You'll have more work, too

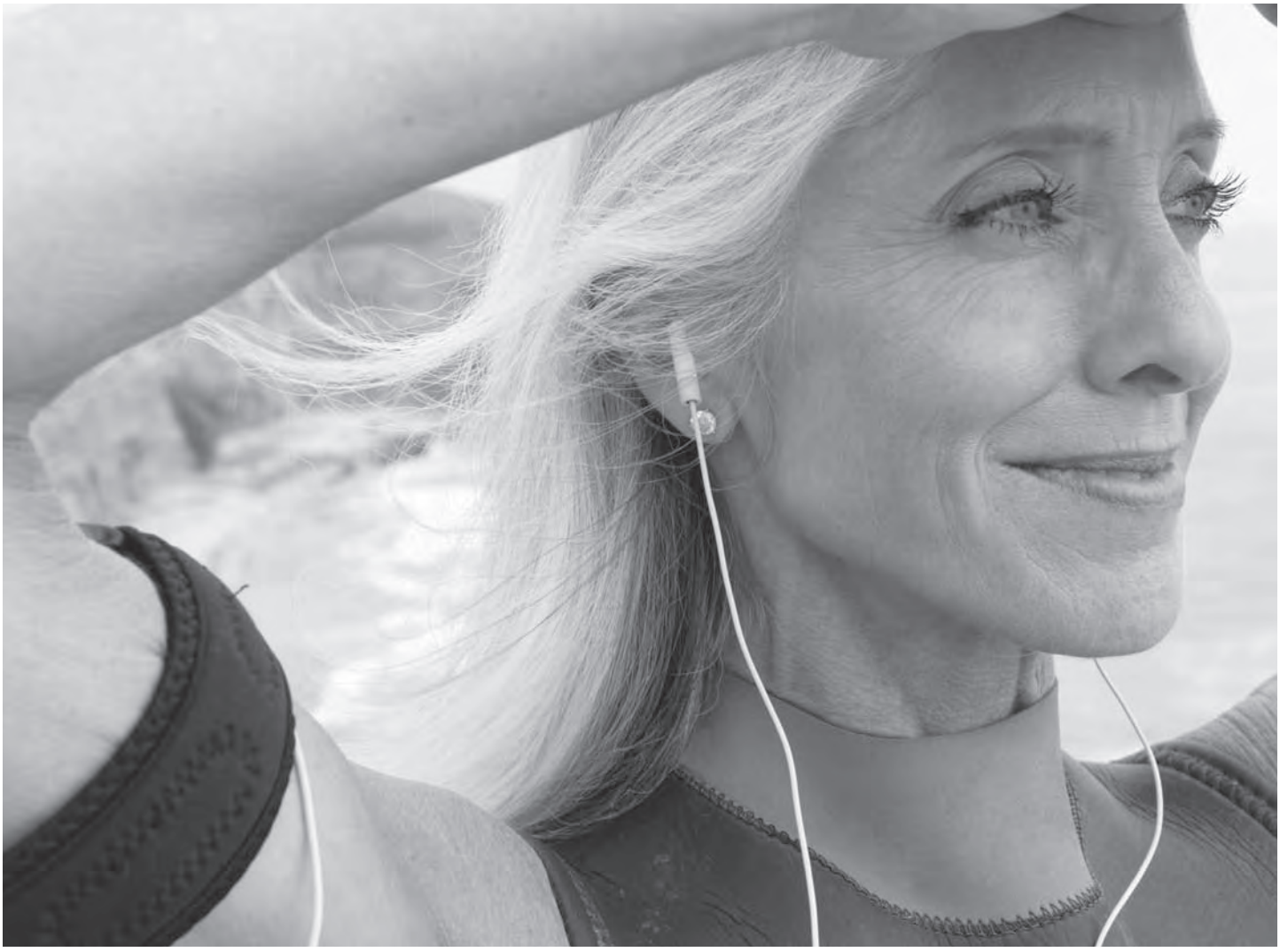
Plus, when you visit an out-of-network doctor, you handle precertification, or preapproval of some health care services, if needed. This means more time and more paperwork for you.

Emergency care is covered

You're covered for emergency care. You have this coverage while you're traveling or at home. This includes students who are away at school. Detailed information can be found in the disclosure section of this packet.

Know your costs before you go

Before you decide where to receive care, look up your estimated costs. It's easy with our cost-of-care tools. Once you're a member, log in to your secure Plan Benefits Navigator℠ member website powered by Aetna Navigator® to use these tools.*



* The Plan Benefits Navigator℠ is powered by Aetna Navigator®. The availability of Plan Benefits Navigator's key features may vary by plan. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage.

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Your Innovation Health catastrophic plan option

Catastrophic plans generally have lower monthly payments and recommended preventive services are covered at 100 percent. Catastrophic plans are only available if you qualify, based on the information you provide when you apply for insurance.

Featuring:

- Innovation Health Basic PD*

The Basic Plan is a catastrophic plan offering. Unlike metal-level coverage, only individuals age 30 and under, or individuals for whom insurance is determined to be unaffordable as evidenced by a hardship exemption, are eligible to enroll in this catastrophic plan.

* This plan includes coverage for pediatric dental (PD).

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Request a quote now

To get a quote or ask a question, you can:

Call your broker.

Call Innovation Health at **1-855-330-4546 (TTY:711)**
Monday – Friday, 8:00 a.m. to 8:00 p.m., ET

Visit **http://www.innovation-health.com**

Innovation Health Basic PD

Innovation Health Plan options in Virginia

Catastrophic

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum, includes pharmacy)	$6,350/$12,700	$12,700/$25,400
Member coinsurance	0%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$15,000/$30,000
Primary care visit	$20 copay, deductible waived 1-3 visits, thereafter 0% after deductible	50% after deductible
Specialist visit	0% after deductible	50% after deductible
Hospital stay	0% after deductible	50% after deductible
Outpatient surgery	0% after deductible	50% after deductible
Emergency room	0% after deductible	
Urgent care	0% after deductible	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	0% after deductible	50% after deductible
Diagnostic X-ray	0% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	0% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	0% after deductible	50% after deductible
Pediatric glasses/ contacts (1 pair lenses and frames OR contacts per year)*	0% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	0% after deductible	30% after deductible
Basic dental care	0% after deductible	50% after deductible
Major dental care	0% after deductible	50% after deductible
Orthodontia (medically necessary only)	0% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible	Integrated Deductible	
Preferred generic drugs	0% after deductible	50% after deductible
Preferred brand drugs	0% after deductible	50% after deductible
Preferred specialty drugs	0% after deductible	Not covered
Nonpreferred drugs (including nonpreferred specialty drugs)	0% after deductible	50% after deductible

* Any applicable benefit maximums are combined in and out of network.

+For important information on your costs and how Innovation Health pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

Health benefits and health insurance plans are offered and/or underwritten by Innovation Health Plan Inc. and Innovation Health Insurance Company. Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) are affiliates of Inova Health System and Aetna Life Insurance Company (Aetna) and its affiliates. Aetna and its affiliates provide certain management services for Innovation Health.

This material is for information only and is not an offer or invitation to contract. Rates and benefits vary by location. Health benefits and health insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Innovation Health. Provider participation may change without notice. Innovation Health does not provide care or guarantee access to health services. 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. Information is believed to be accurate as of the production date; however, it is subject to change.

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Your Innovation Health bronze plan options

Bronze-level plans pay for about 60 percent of covered health care costs. They tend to have lower monthly payments, but you will pay more for your deductible, copayments and coinsurance.

Featuring:

- Innovation Health Advantage 6350 PD*
- Innovation Health AdvantagePlus 5500 PD*

* This plan includes coverage for pediatric dental (PD).

Request a quote now

To get a quote or ask a question, you can:

Call your broker.

Call Innovation Health at **1-855-330-4546 (TTY:711)**
Monday – Friday, 8:00 a.m. to 8:00 p.m., ET

Visit **http://www.innovation-health.com**

Innovation Health Advantage 6350 PD

Innovation Health Plan options in Virginia

Bronze

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum, includes pharmacy)	$6,350/$12,700	$12,700/$25,400
Member coinsurance	0%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$15,000/$30,000
Primary care visit	$20 copay, deductible waived for visits 1-3, thereafter 0% after deductible	50% after deductible
Specialist visit	0% after deductible	50% after deductible
Hospital stay	0% after deductible	50% after deductible
Outpatient surgery	0% after deductible	50% after deductible
Emergency room	0% after deductible	
Urgent care	0% after deductible	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	0% after deductible	50% after deductible
Diagnostic X-ray	0% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	0% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	0% after deductible	50% after deductible
Pediatric glasses/ contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 0% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	$0 copay, deductible waived	30%, deductible waived
Basic dental care	0% after deductible	50% after deductible
Major dental care	0% after deductible	50% after deductible
Orthodontia (medically necessary only)	0% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible	Integrated Deductible	
Preferred generic drugs	0% after deductible	50% after deductible
Preferred brand drugs	0% after deductible	50% after deductible
Preferred specialty drugs	0% after deductible	Not covered
Nonpreferred drugs (including nonpreferred specialty drugs)	0% after deductible	50% after deductible

* Any applicable benefit maximums are combined in and out of network.

+For important information on your costs and how Innovation Health pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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Innovation Health AdvantagePlus 5500 PD

Innovation Health Plan options in Virginia

Bronze

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum, includes pharmacy)	$5,500/$11,000	$11,000/ $22,000
Member coinsurance	10%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$12,700/$25,400
Primary care visit	10% after deductible	50% after deductible
Specialist visit	10% after deductible	50% after deductible
Hospital stay	10% after deductible	50% after deductible
Outpatient surgery	10% after deductible	50% after deductible
Emergency room	10% after deductible	
Urgent care	10% after deductible	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	10% after deductible	50% after deductible
Diagnostic X-ray	10% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	10% after deductible	50% after deductible
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Adult and pediatric eye exam (1 visit per year)*	10% after deductible	50% after deductible
Pediatric glasses/ contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - 0% after deductible; nonpreferred glasses/contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	0% after deductible	30% after deductible
Basic dental care	30% after deductible	50% after deductible
Major dental care	50% after deductible	50% after deductible
Orthodontia (medically necessary only)	50% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible	Integrated Deductible	
Preferred generic drugs	10% after deductible	50% after deductible
Preferred brand drugs	50% after deductible	50% after deductible
Preferred specialty drugs	50% after deductible, not to exceed a $500 copay per prescription	Not covered
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

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Your Innovation Health silver plan options

Silver-level plans pay for about 70 percent of covered health care costs. They tend to have higher monthly payments compared to bronze plans, but you will pay less for your deductible, copayments and coinsurance.

Featuring:

- Innovation Health Classic 5000 PD*
- Innovation Health Classic 3500 PD*

* This plan includes coverage for pediatric dental (PD).

Request a quote now

To get a quote or ask a question, you can:

Call your broker.

Call Innovation Health at **1-855-330-4546 (TTY:711)**
Monday – Friday, 8:00 a.m. to 8:00 p.m., ET

Visit **http://www.innovation-health.com**

Innovation Health Classic 5000 PD

Innovation Health Plan options in Virginia

Silver

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum)	$5,000/$10,000	$10,000/$20,000
Member coinsurance	30%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$12,700/$25,400
Primary care visit	$25 copay, deductible waived	50% after deductible
Specialist visit	$50 copay, deductible waived	50% after deductible
Hospital stay	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible
Emergency room (copay waived if admitted)	$500 copay, deductible waived	
Urgent care	$45 copay, deductible waived	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	30% after deductible	50% after deductible
Diagnostic X-ray	30% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	30% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	$0 copay, deductible waived	50% after deductible
Pediatric glasses/ contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	$0 copay, deductible waived	30%, deductible waived
Basic dental care	30% after deductible	50% after deductible
Major dental care	50% after deductible	50% after deductible
Orthodontia (medically necessary only)	50% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible individual/family (Combined In and out-of-network)	$500 /$1,000	
Preferred generic drugs	$8 copay, deductible waived	50% after $8 copay, deductible waived
Preferred brand drugs	$60 copay after deductible	50% after $60 copay after deductible
Preferred specialty drugs	50% after deductible, not to exceed a $500 copay per prescription	Not covered
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

* Any applicable benefit maximums are combined in and out of network.

+For important information on your costs and how Innovation Health pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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Innovation Health Classic 3500 PD

Innovation Health Plan options in Virginia

Silver

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum)	$3,500/$7,000	$7,000/$14,000
Member coinsurance	20%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$12,700/$25,400
Primary care visit	$25 copay, deductible waived	50% after deductible
Specialist visit	$50 copay, deductible waived	50% after deductible
Hospital stay	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible
Emergency room (copay waived if admitted)	$500 copay, deductible waived	
Urgent care	$45 copay deductible waived	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	20% after deductible	50% after deductible
Diagnostic X-ray	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	$0 copay, deductible waived	50% after deductible
Pediatric glasses/ contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	$0 copay, deductible waived	30%, deductible waived
Basic dental care	30% after deductible	50% after deductible
Major dental care	50% after deductible	50% after deductible
Orthodontia (medically necessary only)	50% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible individual/family (Combined In and out-of-network)	$500 /$1,000	
Preferred generic drugs	$8 copay, deductible waived	50% after $8 copay, deductible waived
Preferred brand drugs	$60 copay after deductible	50% after $60 copay after deductible
Preferred specialty drugs	50% after deductible, not to exceed a $500 copay per prescription	Not covered
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

* Any applicable benefit maximums are combined in and out of network.

+For important information on your costs and how Innovation Health pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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Rating areas*

Virginia

Due to changes related to health care reform, the federal government redefined rating areas. This list shows where Innovation Health Plans are available in your state. Just look for your county below.

Your rates will depend on the area in which your county is located. For more information or a quote on what your rate would be, call your broker or **1-855-330-4546.**

Area 10

Alexandria	Fairfax City
Arlington	Falls Church
Fairfax	Loudoun

71.02.300.1 (1/14)

* Networks may not be available in all zip codes and are subject to change.

Language access services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
1-855-330-4546.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'
1-855-330-4546.

如果需要中文的帮助，请拨打这个号码
1-855-330-4546.

Para obtener asistencia en Español, llame al
1-855-330-4546.

We're here to help

To get help in another language, call
1-855-330-4546.

Eligibility and requirements

Eligibility and requirements: What you need to know

To qualify for an Innovation Health Plan, you must be:

- A resident of the state in which you are applying and a state in which we offer coverage
- Legal U.S. resident

We offer dependent coverage up to age 26.

10-day right to review

Don't cancel your current insurance until we let you know we have accepted you for coverage. We'll review your enrollment form or application to determine if you meet eligibility requirements. If we close your application or enrollment form, we'll let you know by mail. If we approve your application or enrollment form, we'll let you know by mail and send you an Innovation Health Plan contract and ID card.

After reviewing the contract, if you find you're not satisfied for any reason, simply return it to us within 10 days. We'll refund any monthly payment you paid (including any contract fees or other charges), less the cost of any medical or dental services paid on behalf of you or any covered dependent.

Convenient monthly payments

You can save time and money and never miss a payment. You'll have access to tools that allow you to automatically withdraw your monthly payment from your checking account on the due date. You'll save money on checks, envelopes and postage. Plus, you don't have to worry about your payment being late or getting lost in the mail. It's easy to "go green," help the environment and save paper.

To learn more, visit **http://www.innovation-health.com/individuals-families/**

Your coverage

Your coverage stays in effect as long as you pay the required monthly payment on time, and as long as you are eligible in the plan. Coverage will end if you become ineligible due to any of the following circumstances:

- Not paying your monthly bill
- Becoming a resident of a state or location in which Innovation Health Plans aren't available
- Getting duplicate coverage
- Other reasons that the law allows

Levels of coverage and enrollment

These plans are subject to the final rating factors applicable in your state. Once we confirm your eligibility:

- You may be enrolled in your selected plan at the lowest rate available (known as the standard premium charge).
- You may be enrolled in your selected plan at a higher monthly payment due to age, where you live and tobacco use, if applicable in your state.

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Limitations and exclusions

Medical

These medical plans don't cover all health care expenses and include limitations and exclusions. Please refer to your plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. **However, your plan documents may contain exceptions to this list based on state mandates, essential health benefits, or the plan design or rider(s) purchased.**

- All medical and hospital services not specifically covered in, or that are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage ends
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays for individuals age 19 and older
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for individuals age 19 and older or cosmetic purposes
- Hearing aids
- Home births
- Immunizations for travel or work
- 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
- Non-emergency care when traveling outside the U.S.
- Non-medically necessary services or supplies
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Orthotics
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling
- Special or private duty nursing
- 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

Pediatric dental

These medical plans don't cover all pediatric dental care expenses and include limitations and exclusions. Please refer to your plan documents to see which services we cover. The following is a partial list of services and supplies that we generally don't cover. However, your plan documents may have exceptions to this list. We base these documents on state laws, essential health benefits, or the plan design or rider(s) you buy.

- All pediatric dental services not specifically covered in, or that your plan documents limit or exclude, including costs of services before coverage begins and after coverage ends
- Instructions for diet, plaque control and oral hygiene
- Dental services or supplies that you may primarily use to change, improve or enhance appearance
- Dental implants
- Experimental or investigational drugs, devices, treatments or procedures
- Services not necessary for the diagnosis, care or treatment of a condition
- Orthodontic treatment that isn't medically necessary for a severe or handicapping condition
- Replacement of lost or stolen appliances
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease

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Important information about your health benefits – Virginia

For these Innovation Health* medical benefits plans: Open POS Plus

Understanding your plan of benefits

Innovation Health medical benefits plans cover most types of health care from a doctor or hospital. But they do not cover everything. The plan covers recommended preventive care and care that you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans. But some does not. For example, not all plans have deductibles. Information about those topics will only apply if the plan includes those rules.

Where to find information about your specific plan

Your "plan documents" list all the details for the plan you chose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Certificate of Coverage, and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Innovation Health ID card.

Virginia service area

The following counties and cities are in our service area: Alexandria City, Arlington, Fairfax, Fairfax City, Falls Church City, Loudoun.

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. Or, call **1-855-228-0510** Monday through Friday, 7 a.m. to 7 p.m. ET.

Member Services can help you:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Get a referral
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program

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*Innovation Health is the brand name used for products and services provided by Innovation Health Insurance Company and Innovation Health Plan, Inc. Health benefits and health insurance plans are offered and/or underwritten by Innovation Health Plan Inc. and Innovation Health Insurance Company. Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) are affiliates of Inova and Aetna Life Insurance Company (Aetna) and its affiliates. Aetna and its affiliates provide certain management services for Innovation Health.

Contact Virginia state officials

If you need to contact someone about this insurance for any reason, you may also contact your agent, if you have one. If you have been unable to contact us or your agent, or if you are not satisfied with the response, you may contact:

Life and Health Division Bureau of Insurance
PO Box 1157
Richmond, VA 23218
Phone: **804-371-9691**
Fax: **804-371-9944**

or

PO Box 1157
Richmond, VA 23218
Toll-free phone: **1-877-310-6560**
Fax: **804-371-9944**
ombudsman@scc.virginia.gov

Written correspondence is preferred so they have a record of your inquiry. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Innovation Health Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

Help for those who speak another language and for the hearing impaired

Do you need help in another language? Member Services can connect you to a special line where you can talk to someone in your own language. You can also get help with a complaint or appeal.

Language hotline – **1-888-982-3862** *(140 languages are available; ask for an interpreter.)*
TDD 1-800-628-3323 *(hearing impaired only)*

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa – **1-888-982-3862** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*

TDD 1-800-628-3323 *(sólo para personas con impedimentos auditivos)*

Search our network for doctors, hospitals and other health care providers

It's important to know which doctors are in our network. That's because some health plans only let you visit doctors, hospitals and other health care providers if they are in our network. Some plans allow you to go outside the network. But, you pay less when you visit doctors in the network.

Here's how you can find out if your health care provider is in our network.

- Log in to your secure Plan Benefits Navigator℠ powered by Aetna Navigator® member website at **http://www.innovation-health.com**. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Innovation Health ID card. Or call us at **1-855-228-0510**.

For up-to-date information about how to find health care services, please follow the instructions above. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Innovation Health ID card.

Our online directory is more than just a list of doctor's names and addresses. It also includes information about:

- Where the physician attended medical school
- Board certification status
- Language spoken
- Gender
- And more

You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

Costs and rules for using your plan

What you pay

You will share in the cost of your health care. These are called "out-of-pocket" costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- Copay – a set amount (for example, $15) you pay for covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.
- Coinsurance – your share of the costs for a covered service. This is usually a percent (for example, 20%) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

- Deductible – the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay for some services. Other deductibles may apply at the same time.
  - Inpatient hospital deductible – applies when you are a patient in a hospital
  - Emergency room deductible – the amount you pay when you go to the emergency room, waived if you are admitted to the hospital within 24 hours

Note: These are separate from your general deductible. For example, your plan may have a $1,000 general deductible and a $250 emergency room deductible. This means you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.

Your costs when you go outside the network

Plans that cover out-of-network services

With Open POS Plus plans, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on if the provider, such as a doctor or hospital, is "in network" or "out of network." We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care. The following are examples for when you see a doctor:

In network means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance or copayments, along with any deductible. Your network doctor will handle any precertification required by your plan.

Out of network means we do not have a contract with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Innovation Health medical plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be much higher than what your Innovation Health plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that your plan doesn't "recognize." You must also pay any copayments, coinsurance and deductibles that apply. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount we allow for a service or procedure.

How we pay doctors who are not in our network

When you choose to see an out-of-network doctor, hospital or other health care provider, we pay for your care using a "prevailing" or "reasonable" charge obtained from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Innovation Health plan will state which method is used.

See "Emergency and urgent care and care after office hours" for more information.

Going in network just makes sense

- We have negotiated discounted rates for you.
- In-network doctors and hospitals won't bill you for costs above our rates for covered services.

To learn more about how we pay out-of-network benefits, visit **http://www.innovation-health.com.**

Precertification: getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." You usually only need precertification for more serious care like surgery or being admitted to a hospital. When you get care from a doctor in the network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification when that's required.

Your plan documents list all the services that require you to get precertification. If you don't, you will have to pay for all or a larger share of the cost for the service. Even with precertification, you will usually pay more when you use out-of-network doctors.

Call the number shown on your Innovation Health ID card to begin the process. You must get precertification before you receive the care.

You do not have to get precertification for emergency services.

What we look for when reviewing a precertification request

First, we check to see that you are still a member. And we make sure the service is considered medically necessary

for your condition. We also make sure the service and place requested to perform the service are cost effective. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may contact you.

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Information about specific benefits

Emergency and urgent care and care after office hours

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect that you could die or risk your health. For a pregnant woman, that includes her unborn child.

Emergency care is covered anytime, anywhere in the world. If you need emergency care, follow these guidelines:

- Call 911 or go to the nearest emergency room. If you have time, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- You do not have to get approval for emergency services.

We will review the information when a claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

You could pay more when getting emergency care outside the network

Sometimes you don't have a choice about where you go for care. Like if you go to the emergency room for a heart attack. When you need emergency care, some of our plans pay the bill as if you got care in network. For those plans, you pay cost sharing and deductibles based on your in-network level of benefits. You do not have to pay anything else. Some of our plans pay differently. When you get emergency services out of our network, your plan typically will pay part of the bill. The plan's payment for emergency services is usually based on the rates Innovation Health pays health care providers in our network for those services in the area where you get the emergency care. Sometimes, the plan's payment is based on other methods, such as the local rate set by Medicare. You may be responsible for any amounts above what Innovation Health covers. Those additional amounts could be very large and would be in addition to your plan's cost sharing and deductibles.

To find out how emergency services are covered under your plan, look at your health plan document called "Certificate of Coverage" or "Summary Plan Description." Or contact us at the number on your member card.

Learn which in-network emergency care centers are in your area

You can avoid high out-of-pocket amounts by using hospitals and emergency care centers in our network. For a list in your local area, use our DocFind® search tool at **http://www.innovation-health.com/individuals-families**. Click on "Find a Doctor." You can also call Member Services at the toll-free number on your Innovation Health ID card. It's a good idea to know which local emergency care centers are in the network before you have an emergency.

Follow-up care for plans that require a PCP

You may need to follow up with a doctor after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. Your PCP should coordinate all follow-up care. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care – available 24/7

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to **http://www.innovation-health.com** and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Prescription drug benefits

Innovation Health pharmacy benefits are administered by Aetna.

Some plans encourage generic drugs over brand-name drugs
A generic drug is the same as a brand-name drug in dose, use and form. They are Food and Drug Administration (FDA) approved and safe to use. Generic drugs usually sell for less, so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for it. You'll pay your normal share of the cost, and you'll also pay the difference in the two prices.

We may also encourage you to use certain drugs
Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share of the cost for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This list shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be on the list.

When you get a drug that is not on the preferred drug list, your share of the cost will usually be more. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an "open formulary," but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug company rebates

Drug companies may give us rebates when our members buy certain drugs. We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug list. They may also apply to drugs not on the list. In plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug on the preferred drug list than for a drug not on the list.

Mail-order and specialty-drug services from Aetna- owned pharmacies – Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®
Mail-order and specialty drug services are from pharmacies that Aetna owns. These are for-profit pharmacies.

You might not have to stick to the list
Sometimes your doctor might recommend a drug that's not on the preferred drug list. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

You may have to try one drug before you can try another
Step therapy means you have to try one or more drugs before a "step-therapy" drug will be covered. The preferred drug list includes step-therapy drugs. Your doctor might want you to skip one of these drugs for medical reasons. If so, you, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

Some drugs are not covered at all
Prescription drug plans do not cover drugs that don't need a prescription. Your plan documents might also list specific drugs that are not covered. You cannot get a medical exception for these drugs.

New drugs may not be covered
Your plan may not cover drugs that we haven't reviewed yet. You, someone helping you, or your doctor may have to get our approval to use one of these new drugs.

Get a copy of the preferred drug list
You can find the Aetna Preferred Drug Guide by logging in to your secure Plan Benefits Navigator member website at **http://www.innovation-health.com**. You can also ask for a printed copy by calling the toll-free number on your Innovation Health ID card. We are constantly adding new drugs to the list. Look online or call Member Services for the latest updates.

Have questions? Get answers.

Ask your doctor about specific medications. Call the number on your Innovation Health ID card to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

Mental health and addiction benefits

Here's how to get mental health services:

- Call 911 if it's an emergency.
- Call the toll-free Behavioral Health number on your Innovation Health ID card.
- Call Member Services if no other number is listed.
- Call an Employee Assistance Program (EAP) professional, who can also help you find a mental health specialist.

Mental health programs to help prevent depression

- Perinatal Depression Education, Screening and Treatment Referral, and
- Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention

Call Member Services for more information on either of these prevention programs. Ask for the phone number of your local Care Management Center.

Transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Breast reconstruction benefits

Notice regarding Women's Health and Cancer Rights Act of 1998

Coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymph edemas.

We will talk to you and your doctor about these rules when we provide the coverage. We will also follow your plan design. For example, the following may apply to your breast reconstruction benefits as outlined in your plan design:

- Limitations
- Copays
- Deductibles
- Referral requirements

If you have any questions about this coverage, please contact the Member Services number on your ID card.

Also, you can visit the following websites for more information:

U.S. Department of Health and Human Services – **http://cciio.cms.gov/programs/protections/WHCRA/whcra_factsheet.html**

U.S. Department of Labor – **http://www.dol.gov/dol/topic/health-plans/womens.htm**

Knowing what is covered

You can avoid unexpected bills with a simple call to Member Services. Call the toll-free number on your ID card to find out what's covered before you receive the care.

Here are some of the ways we determine what is covered:

We check if it's "medically necessary"

Medical necessity is more than being ordered by a doctor. "Medically necessary" means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition. Or to check if you have one. Or it might be to treat an injury or illness.

The product or service:

- Must meet a normal standard of care for doctors
- Must be the right type in the right amount for the right length of time and for the right body part
- Must be known to help the particular symptom
- Cannot be for the member's or the doctor's convenience
- Cannot cost more than another service or product that is just as effective

Only medical professionals can decide if a treatment or service is not medically necessary. We do not reward our employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Doctors can write or call our Patient Management department with questions. Contact Member Services at the phone number on your Innovation Health ID card for the appropriate address and phone number.

We study the latest medical technology

We look at scientific evidence published in medical journals to help us decide what is medically necessary. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and mental health treatments. Plus, we look at new ways to use old technologies. To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins

We post our findings on **http://www.innovation-health.com**

We write a report about a product or service after we decide if it is medically necessary. We call the report a Clinical Policy Bulletin (CPB).

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents.

CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can read our CPBs on our website at **http://www.innovation-health.com**. No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any product or service.

We can help when more serious care is recommended

We may review a request for coverage to be sure the service is in line with recognized guidelines. Then we follow up. We call this "utilization management review."

First, we begin this process if your hospital stay lasts longer than what was approved. We make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting.

Second, we begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you're home.

Third, we may review your case after your discharge. We may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

We follow specific rules to help us make your health a top concern:

- We do not reward our employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care. Where such use is appropriate, our staff uses nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review claims. Physicians' groups, such as independent practice associations, may use other resources they deem appropriate.

What to do if you disagree with us

Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

The following is the exact procedure as outlined in your plan documents. However, know that you can always start the process or learn your next steps with a simple call to Member Services.

These procedures govern administrative complaints and grievances made or submitted by members.

A. Definitions

1. An "administrative complaint" is an oral or written contact from a member who expresses dissatisfaction regarding: i. The direct provision or quality of care by a participating health care provider; ii. The quality of administrative service provided by a participating health care provider; or iii. The quality of administrative service provided by Innovation Health.
2. An "adverse decision" means a utilization review determination by Innovation Health that: i. A health care service rendered or proposed to be rendered that would otherwise be covered under the member's contract is not or was not medically necessary, appropriate or efficient; and ii. May result in noncoverage of the health care service. An adverse decision does not include a decision concerning a person's status as a member.
3. An "appeal" means a request for reconsideration of a grievance.
4. A "final adverse decision" means a utilization review determination made by a physician advisor or peer of the treating health care provider in a reconsideration of an adverse decision, and upon which a provider or member may base an appeal.

5. A “grievance” means an oral or written request for reconsideration, filed by a member or health care provider on behalf of a member with Innovation Health through our internal grievance process regarding an adverse decision or administrative complaint concerning the member.
6. A “peer of the treating health care provider” means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

B. Reconsideration of an Innovation Health decision – Level I

1. Members with administrative complaints should contact us, either verbally or in writing, at the Innovation Health address and telephone number listed on the agreement. Administrative complaints will be routed to the appropriate Innovation Health department for resolution. If a member is not satisfied with the resolution of their administrative complaint, they may file a written grievance. The grievance should contain sufficient information for us to investigate and render a decision.
2. Members who wish to request a reconsideration of an adverse decision should file a grievance with us at the following address and telephone numbers:

   PO Box 981107
   El Paso, TX 79998-1107
   Fax: **859-425-3379**
   Phone: Call the toll-free number on your Innovation Health ID card
3. The Complaint and Appeals unit will send a written notice to the member within two (2) working days of this initial contact. The notice will include the following:

- An acknowledgement that the grievance was received
- The name, address and telephone number of the Regional Grievance Unit
- Instructions on how to submit written materials
- The details of the internal appeal process and procedures
- If necessary for the review, a release form for the member’s signature for the purpose of obtaining medical records or other information that may require their authorization for release
- Information about the Bureau of Insurance’s Managed Care Ombudsman including the following mailing address, telephone number and e-mail address:

  PO Box 1157
  Richmond, VA 23218
  Toll-free phone: **1-877-310-6560**
  Fax: **804-371-9944**
  ombudsman@scc.virginia.gov

Grievances will be handled as follows: The Regional Grievance Unit will review all of the information submitted and gather any additional information necessary to prepare and render a decision about the grievance. If there is insufficient information available to make a decision, the Regional Grievance Unit will, within five (5) working days of receipt of the grievance, notify the member or health care provider on behalf of the member of the need for additional information.

The Regional Grievance Unit will also offer to assist the member or health care provider obtain the information. The Regional Grievance Unit will review, render a final adverse decision or grievance decision and send a written notice to the member or the health care provider, if filed on behalf of the member, within 10 working days of receipt of the grievance.

This notice will include:

- The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale
- A statement that a list of individuals participating in the review of the grievance, along with their titles and credentials, is available on request
- A statement of the reviewer’s understanding of the pertinent facts of the grievance
- A reference to the specific criteria and standards, including interpretive guidelines on which the decision was based
- A reference to the evidence or documentation used as the basis for the decision
- If the decision is upheld, a description of the member’s right to an appeal hearing and the procedure for requesting the hearing

C. Appeal hearing – Level II

1. The member has 30 days from the notification of the Level I decision to request a Level II appeal hearing.
2. Upon receipt of a written request for a Level II appeal hearing, we will provide the member filing the request with the procedures governing appeal hearings. The member will be notified of the member's right to have an uninvolved Innovation Health representative available to assist the member in understanding the appeal hearing process.
3. A review body at the local market (hereinafter the "Appeal Hearing Panel") will be formed to handle the appeal hearing. The reviewers must not have participated in any prior review determinations. The composition of the review body must be peers of the treating health care provider (physician to physician; chiropractor to chiropractor) and must be board certified or board eligible in a discipline pertinent to the issue under review, if the appeal involves a medical necessity issue.
4. We will hold appeal hearings in our offices on a certain day each month to consider all appeals filed seven (7) working days or more in advance of the hearing day. We will send written notification to the member indicating the time, date and location of the hearing.
5. In the event a member is unable to attend the hearing on the scheduled hearing day, the appeal will be heard in the member's absence.
6. The member will have the right to attend the appeal hearing, question the Innovation Health representative designated to appear at the hearing and any other witnesses, and present their case. The member will also have the right to be assisted or represented by a person of the member's choice, and to submit written material in support of their appeal. The member may bring a physician or other expert(s) to testify on the member's behalf. We will also have the right to present witnesses. Counsel for the member may present the member's case and question witnesses, if the member is so represented. Similarly, we may also choose to be represented by counsel. The Appeal Hearing Panel will have the right to question the Innovation Health representative, the member and any other witnesses.
7. The appeal hearing will be informal. The Appeal Hearing Panel will not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Hearing Panel will have the right to exclude redundant testimony or excessive argument by any party or witness.
8. A written record of the appeal hearing will be made by stenographic transcription. All testimony will be under oath.
9. Before the record is closed, the Chair of the Appeal Hearing Panel will ask both the member and the Innovation Health representative (or their counsel) whether there is any additional evidence or argument the party wishes to present to the Appeal Hearing Panel. Once all evidence and arguments have been received, the record of the appeal hearing will be closed. The deliberations of the Appeal Hearing Panel will be confidential and will not be transcribed.
10. The Appeal Hearing Panel will render a written decision within five (5) working days of the conclusion of the appeal hearing.
11. The Appeal Hearing decision will be made within 30 days of receipt of the member's request. The written decision will contain:
    - The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness) rationale
    - A statement that a list of individuals participating in the review of the appeal, along with their titles and credentials, is available on request
    - A statement of the Appeal Hearing Panel's understanding of the pertinent facts of the appeal
    - A reference to the evidence or documentation used as the basis for the decision, and in the cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used

D. External review

We also offer members an external review process. This process allows members to have their adverse decisions reviewed by an Independent Utilization Review Organization. A member may obtain an external review of their coverage denial from an Innovation Health contracted External Review Organization (ERO) if the denial is based on the lack of medical necessity or the experimental or investigational nature of the proposed treatment. Instructions on how to request an external review are included with the Appeal Hearing Panel's response to the second level appeal.

E. Expedited review of adverse decisions

1. The member or health care provider on behalf of the member may request an expedited review when an adverse decision is rendered for health care services that are proposed but have not been delivered, and the services are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or would cause the member to be a danger to him/herself or others. The member and health care provider will be notified immediately if we do not have sufficient information to complete the expedited review and we will assist the member or health care provider in gathering the necessary information without further delay.
2. Expedited reviews will be performed by a physician advisor, a peer of the treating health care provider or a panel of other appropriate health care providers, at least one of which is a physician advisor.
3. Expedited reviews will be completed within 24 hours of the time the member or health care provider initiates the request.
4. Within one (1) day after a decision has been orally communicated to the member or health care provider, a written notice will be sent to the member or health care provider. The notice will include:
   - The decision, in clear terms, with the contractual (benefits) or clinical (medical appropriateness)
   - Rationale
   - A list of individuals participating in the review, along with their titles and credentials, is available on request
   - A statement of the reviewer's understanding of the pertinent facts of the review
   - A reference to the evidence or documentation used as the basis for the decision, and in cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used
   - If the denial is upheld, a statement advising the member or health care provider of their right to file a grievance and a description of how to file a grievance
   - Information about the Bureau of Insurance's Managed Care Ombudsman including the following mailing address, telephone number and e-mail address:

     PO Box 1157
     Richmond, VA 23218
     Toll-free phone: **1-877-310-6560**
     Fax: **804-371-9944**
     ombudsman@scc.virginia.gov
5. If the expedited review is a concurrent review determination, the service should be continued without liability to the member until the member is notified of the decision, unless it is related to an initial unauthorized admission.
6. We are not required to provide an expedited review for retrospective noncertifications.

F. Record retention

We will retain the records of all grievances and appeals for a period of at least seven (7) years.

G. Fees and costs

Nothing herein will be construed to require us to pay counsel fees or any other fees or costs incurred by a member in pursuing a grievance or appeal. We are subject to regulation in the Commonwealth of Virginia by the State Corporation Commission Bureau of Insurance, pursuant to Title 38.2, and the Virginia Department of Health, pursuant to Title 32.1.

Member rights & responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures. This includes our Member Rights and Responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit **http://www.innovation-health.com**. Enter "Rights & Resources" into the search bar. You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

An "advanced directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advanced directive to receive care. But you have the right to create one. Hospitals may ask if you have an advanced directive when you are admitted.

There are three types of advanced directives:

- Durable power of attorney – names the person you want to make medical decisions for you
- Living will – spells out the type and extent of care you want to receive
- Do-not-resuscitate order – states that you don't want CPR if your heart stops or a breathing tube if you stop breathing

You can create an advanced directive in several ways:

- Ask your doctor for an advanced directive form.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.
- Work with a lawyer to write an advanced directive.
- Create an advanced directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advanced Directives and Do Not Resuscitate Orders. January 2012. Available at **http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html** Accessed April 2, 2013

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, you can call Member Services to ask for a printed copy. See the "Contact Us" section of this disclosure.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean:

- Information about your physical or mental health
- Information about the health care you receive
- Information about what your health care costs

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Innovation Health Privacy Policy

When necessary for your care or treatment, the operation of our health plans, or other related activities, we use personal information within our company, share it with our affiliates, and may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs
- Other insurers
- Vendors
- Government authorities
- Third-party administrators

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

- Paying claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve our plans
- Audits

We consider these activities key for the operation of our health plans. If allowed by law, we usually will not ask if it's okay to use your information. However, we will ask for your permission to use your information for marketing purposes. We have policies in place if you are unable to give us permission to use your information. We are required to give you access to your information. You may also request corrections to your personal information. We must fulfill your requests within a reasonable amount of time.

If you'd like a copy of our privacy policy, call the toll-free number on your ID card or visit us at **http://www.innovation-health.com**.

Anyone can get health care

We do not consider your race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are legally required to do the same.

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

How we use information about your race, ethnicity and the language you speak

You choose if you want to tell us your race/ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care. We also use it to help serve you better. See "We protect your privacy" to learn more about how we use and protect your private information. See also "Anyone can get health care."

Your rights to enroll later if you decide not to enroll now

When you lose your other coverage

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

Getting proof that you had previous coverage

We may ask for proof that you had previous coverage when you apply. Other insurers may do the same. This helps determine if you are eligible for the plan. Your plan sponsor may have contracted with us to issue a certificate. Ask us for a Certificate of Prior Health Coverage anytime you want to check the status of your coverage. If you lost your coverage, you have 24 months to make this request. Just call Member Services at the toll-free number on your ID card.

Better manage your health and health care

Your secure member website

Your Plan Benefits Navigator℠ member website powered by Aetna Navigator®* puts all of your plan information and cost-saving tools in one place. It's where you can go 24/7 to:

- Find the right doctor — and save money. Locate in-network doctors who accept your plan.
- See what you owe. Look up claims to see how much the plan paid and what you may have to pay.
- Know your plan. Check who is covered by your plan and what it covers.
- Get valuable information. See which doctors and hospitals have met extra standards for quality and efficiency.
- Know costs before you go. See cost estimates before you make an appointment for an office visit, test or procedure.
- Get healthier. Take a health assessment to learn about your health and how to lower your risks.
- Check your health accounts. Easily look up your health savings account or health fund balances.

Our easy-to-use tools help you make the most of your plan's benefits. Log in today at **http://www.innovation-health.com.**

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* The Plan Benefits Navigator℠ is powered by Aetna Navigator®. The availability of Plan Benefits Navigator's key features may vary by plan. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage.

Ready to enroll?

Visit **http://www.innovation-health.com/individuals-families/** to complete the enrollment form online.

Health benefits and health insurance plans are offered and/or underwritten by Innovation Health Plan Inc. and Innovation Health Insurance Company. Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) are affiliates of Inova Health System and Aetna Life Insurance Company (Aetna) and its affiliates. Aetna and its affiliates provide certain management services for Innovation Health.

This material is for information only. Plan features and availability may vary by location. Rates and benefits may vary by location. Health benefits and insurance plans and dental insurance plans contain exclusions and limitations. Investment services are independently offered by the HSA administrator. Providers are independent contractors and are not agents of Aetna or Innovation Health. Provider participation may change without notice. We do not provide care or guarantee access to health services. Not all health/dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. 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 refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy providing prescription services by mail. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of production date; however, it is subject to change.

For more information about Innovation Health plans, refer to **http://www.innovation-health.com.**

You can always visit us online for more information: http://www.innovation-health.com

How did we do?

Scan to tell us if we gave you what you need to make your enrollment decision. Thank you. We look forward to serving you.

You can also visit us online to complete the survey.
Go to **http://go.aetna.com/IHfeedback**

http://www.innovation-health.com

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