# UNIVERSITY OF VIRGINIA HEALTH PLAN
# 2020 SCHEDULE OF BENEFITS
# VALUE HEALTH OOA

| SERVICES PROVIDED | IN-NETWORK[1] | OUT-OF-NETWORK[2] |
|---|---|---|
| | **Direct Access through Aetna Provider Network** | **Care provided by non-participating providers** |
| **1. PLAN COINSURANCE** Applies to all expenses unless otherwise stated. | | |
| | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **2. PROFESSIONAL SERVICES IN OFFICE OR OUTPATIENT** | | |
| A. Primary Care Physician Visit | $25 Copayment | Deductible & 40% Coinsurance |
| B. Specialty Care Visit | $50 Copayment | Deductible & 40% Coinsurance |
| C. Maternity Visit | Paid in Full[3] | Deductible & 40% Coinsurance |
| **3. PREVENTIVE CARE AND IMMUNIZATIONS** | | |
| A. Preventive General Physical Examination (PCP Only) | Paid in Full | Available In-Network Only |
| B. Preventive Well Child Care (Under Age 7) (PCP Only) | Paid in Full | Available In-Network Only |
| C. Preventive Diagnostic Tests, Laboratory Services and XRay Procedures (Non-Urgent Only) | Paid in Full[3] | Available In-Network Only |
| D. For Common Communicable Diseases as per CDC Guidelines excluding those used for Foreign Travel | Paid in Full | Available In-Network Only |
| **4. URGENT CARE CENTER** *(Must be an unexpected illness or injury where services are needed sooner than a routine doctor's visit)* | | |
| | Deductible & 20% Coinsurance | |

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| **5. EMERGENCY ROOM SERVICES** Emergency Room Services will be processed under the Hospital Care Benefits if patient is admitted. *(Must be an emergency to receive benefits.)* | | |
| Emergency Room Visit | Deductible & 25% Coinsurance | |
| Other Associated Charges | Deductible & 25% Coinsurance | |
| **6. INPATIENT HOSPITAL** | | |
| A. Inpatient Care (Semi-Private Accommodations Unless Private Accommodations are Approved for Medical Reasons) | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| B. Limitation on Inpatient Days | Unlimited | Unlimited |
| C. Other Associated Charges | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **7. TRANSPLANT SERVICES** Using Aetna's Institutes of Excellence Network only | | |
| Inpatient Services and Other Associated Charges | Deductible & 20% Coinsurance | Available In-Network Only |
| **8. BARIATRIC SERVICES** Using Aetna's Institutes of Quality Network only | | |
| Inpatient Services and Other Associated Charges | Deductible & 20% Coinsurance | Available In-Network Only |
| **9. OUTPATIENT HOSPITAL** | | |
| Outpatient Procedures and Other Associated Charges | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **10. SKILLED NURSING FACILITY** | | |
| Skilled Nursing / Rehabilitation Facility (180 Days Per Year Combined Maximum) | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **11. HOME HEALTH SERVICES** | | |
| Medically Necessary Services Approved By Claims Administrator (90 Visits Per Year Maximum) | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |

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|---|---|---|
| **12. AMBULANCE TRANSPORTATION** | | |
| Local Ground or Air Transportation When Medically Necessary To and/or From a Hospital | Deductible & 20% Coinsurance | Deductible & 20% Coinsurance |
| **13. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES** | | |
| A. Inpatient Acute Care for Non-Biologically Based Mental Illnesses | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| B. Inpatient Care for Biologically Based Mental Illnesses | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| C. Outpatient Treatment for Non-Biologically Based Mental Health Illnesses | $20 Copayment | Deductible & 40% Coinsurance |
| D. Outpatient Treatment for Biologically Based Mental Illnesses | $20 Copayment | Deductible & 40% Coinsurance |
| **14. SPEECH THERAPY** | | |
| Medically Necessary Restorative Services, Non-developmental Conditions except under age 5 (40 Visits Per Year Maximum) | $40 Copayment | Deductible & 40% Coinsurance |
| **15. PHYSICAL/ OCCUPATIONAL THERAPY** | | |
| Medically Necessary Restorative Services, Non-developmental Conditions except Occupational Therapy under age 5 (40 Visits Per Year Combined Maximum) | $40 Copayment | Deductible & 40% Coinsurance |
| **16. CHIROPRACTIC CARE** | | |
| 26 Spinal Manipulations Per Year Maximum | $40 Copayment | Deductible & 40% Coinsurance |
| **17. ACUPUNCTURE** | | |
| Medically Necessary Acupuncture Services (20 Visits Per Year Maximum) | $40 Copayment | Deductible & 40% Coinsurance |

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|---|---|---|
| **18. DURABLE MEDICAL EQUIPMENT** | | |
| Medically Necessary Equipment, Prosthetic Appliances, and Medical Supplies | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **19. PRESCRIPTION DRUGS** | Using Participating Pharmacies | |
| Covered drugs are evaluated and selected from OptumRx's Premium Formulary.<br><br>Covered drugs require a written prescription and approval by FDA. Participating Pharmacy cost-sharing is detailed on this schedule.<br><br>The Plan mandates Generic Substitution: Coverage is limited to cost of Generic when available.<br><br>*When a Generic equivalent exists for a Brand Name prescription, the Enrollee will be required to pay the difference in the cost between the Brand Name drug and the Generic drug in addition to the appropriate Copayment if the Brand Name drug is selected*[4]. | ***Retail Pharmacy Network:*** $6 (Tier 1), Deductible & 20% with $34 minimum/$150 maximum (Tier 2), and Deductible & 20% with $68 minimum/$225 maximum (Tier 3) cost sharing per prescription for up to a *30-day supply at Participating Pharmacies* only; annual deductible applicable to Tier 2 and Tier 3 retail drugs. ***When using UVA Pharmacies:*** $6 (Tier 1), Deductible & 20% with $150 maximum (Tier 2), and Deductible & 20% with $225 maximum (Tier 3) cost sharing per prescription for up to a *30-day supply;* annual deductible applicable to Tier 2 and Tier 3 retail drugs. UVA Pharmacies include UVA Pharmacy, Emily Couric Clinical Cancer Center Pharmacy, UVA Bookstore Pharmacy, Zion Crossroads Pharmacy, and UVA Cancer Center Augusta Pharmacy.<br><br>***OptumRx Home Delivery:*** $14 (Tier 1), 15% with $75 minimum/$375 maximum (Tier 2), and 15% coinsurance with $150 minimum/$475 maximum (Tier 3) cost sharing per prescription for up to *90-day supply through mail order.*<br><br>*31- to 90-day supply* may be purchased at *Participating Retail Pharmacies* with no discounted copayment.<br><br>Specialty Drugs are available only in a supply *up to 30 days*. Specialty Drugs must be filled through ***UVA Specialty Pharmacy in order to be covered:*** 20% with $100 maximum (Tier 1), 20% with $150 maximum (Tier 2), and 20% with $200 maximum (Tier 3) cost sharing per prescription.<br><br>Most non-covered prescription drugs approved by FDA as non-investigational or non-experimental can be filled with 100% coinsurance at the OptumRx discount price per prescription at Participating Pharmacies only. Cost-sharing for these non-covered drugs does not count towards the deductible or out-of-pocket maximum[4].<br><br>Contraceptive drugs and devices are covered. Over-the-counter preventive items mandated by the federal health care reform law are covered with a prescription. Other over-the-counter items are not covered. | |
| **20. CALENDAR YEAR DEDUCTIBLE** | Deductible is applicable to services and covered Prescriptions that have Coinsurance; deductible is not applicable to services or Prescriptions that have Copayments or to Amounts above the Allowable Amount[4]. | |
| A. Per Individual | $800 | $1,600 |
| B. Per Family | $1,600 | $3,200 |
| **21. MAXIMUM OUT-OF-POCKET** | Includes Coinsurance, Deductible, Copayments, and covered Prescriptions; Excludes Amounts above the Allowable Amount[4]. | |
| A. Per Individual | $5,500 | $11,000 |
| B. Per Family | $11,000 | $22,000 |

[1]Participants living outside the United States for 90 consecutive days or longer who complete a special Foreign Country Enrollment Form available from the UVA Total Rewards Division may use providers in the country in which they are residing as in-network providers for health services with the exception of transplants and bariatric services. All transplant services must be performed by Aetna Institutes of Excellence Network Providers. All bariatric services must be performed by Aetna Institutes of Quality Network Providers. Health services received in the U.S. must be provided by Aetna participating providers to be eligible for in-network benefits.

[2]OON cost sharing amounts are based on the Allowable Amount which is defined as the amount the Claims Administrator will pay for any covered service before any applicable cost sharing amount. Participants are responsible for amounts above the Allowable Amount if they use non-participating providers which may be significant. Participants are also responsible for obtaining any necessary Preauthorization when using non-participating providers (Out-of-Network Option). Failure to obtain Preauthorization may result in denial of benefits. Call the Claims Administrator's Customer Service Department prior to accessing services to determine whether Preauthorization is necessary. Claims will be denied entirely if not medically necessary.

[3]Value Health will pay 100% of in-network preventive diagnostic, laboratory, and xray procedures. The plan coinsurance will be applied for in-network non-preventive diagnostic, laboratory, and xray procedures after the annual deductible has been met.

[4]When a generic equivalent exists for a brand name prescription and the enrollee selects the brand name drug, the brand name prescription cost-sharing and the difference in the cost between the brand name drug and the generic drug are not included in the deductible or out-of-pocket amount. Neither is cost-sharing for non-covered prescriptions or services.