UNIVERSITY OF VIRGINIA HEALTH PLAN
2022 SCHEDULE OF AETNA NATIONAL NETWORK BENEFITS
COMPARISON OF BASIC HEALTH, VALUE HEALTH, AND CHOICE HEALTH

COVERED SERVICES	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
PLAN COINSURANCE Applies to all expenses unless otherwise stated.			
	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
ANNUAL 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 or to penalties[2].			
	$2,000 for employee only	$800 per individual	$500 per individual
	$4,000 for E+spouse, E+children, family	$1,600 per family	$1,000 per family
OUT-OF-POCKET MAXIMUM Includes coinsurance, deductible, copayments and covered prescriptions; Excludes amounts above allowable amount and penalties[2].			
Per Individual	$5,500	$5,500	$5,500
Per Family	$11,000	$11,000	$11,000
PROFESSIONAL SERVICES IN OFFICE OR OUTPATIENT			
Primary Care Physician Visit	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
Specialty Care Visit	Deductible & 20% Coinsurance	$80 Copayment	Deductible & 15% Coinsurance
Maternity Visit (routine prenatal)	Paid in Full[1]	Paid in Full[1]	Paid in Full[1]
Other associated charges	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
TELADOC CONSULTATIONS Using Teladoc provider network only			
Virtual access to doctors for general medicine, behavioral healthcare, dermatology, and caregiving	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
PREVENTIVE CARE AND IMMUNIZATIONS			
Preventive General Physical Examination (PCP Only)	Paid in Full	Paid in Full	Paid in Full
Preventive Well Child Care (Under Age 7) (PCP Only)	Paid in Full	Paid in Full	Paid in Full
Preventive Diagnostic Tests, Laboratory Services and XRay Procedures (Non-Urgent Only)	Paid in Full[1]	Paid in Full[1]	Paid in Full[1]

COVERED SERVICES	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
For Common Communicable Diseases as per CDC Guidelines excluding those used for Foreign Travel	Paid in Full	Paid in Full	Paid in Full
URGENT CARE CENTER *(Must be an unexpected illness or injury where services are needed sooner than a routine doctor's visit)*			
	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
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	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance
Other Associated Charges	Deductible & 25% Coinsurance	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance
INPATIENT HOSPITAL			
Inpatient Care (Semi-Private Accommodations Unless Private Accommodations are Approved for Medical Reasons)	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
Limitation on Inpatient Days	Unlimited	Unlimited	Unlimited
TRANSPLANT SERVICES Using Aetna's Institutes of Excellence Network only			
Inpatient Services and Other Associated Charges	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
BARIATRIC SERVICES Using Aetna's Institutes of Quality Network only			
Inpatient Services and Other Associated Charges	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
OUTPATIENT HOSPITAL			
Outpatient Procedures	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
Other Associated Charges	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
EARLY INTERVENTION SERVICES Lifetime maximum of $5,000 per covered member for all covered medical services			
Primary Care Physician Visit	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
Specialty Care Visit	Deductible & 20% Coinsurance	$80 Copayment	Deductible & 15% Coinsurance
INFERTILITY SERVICES			
Comprehensive Infertility and Advanced Reproductive Technology	Lifetime maximum of $15,000 for medical and Rx services per subscriber and their covered spouse; no coverage for dependent children		
Treatment after diagnosis	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
SKILLED NURSING FACILITY			

COVERED SERVICES	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
Skilled Nursing / Rehabilitation Facility (180 Days Per Year Combined Maximum)	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
HOSPICE CARE			
Inpatient and outpatient services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
HOME HEALTH SERVICES			
Medically Necessary Services Approved By Claims Administrator (90 Visits Per Year Maximum)	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
AMBULANCE TRANSPORTATION			
Local Ground or Air Transportation When Medically Necessary To and/or From a Hospital	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Inpatient Hospital and Residential Treatment	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
Outpatient Treatment	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
SPEECH THERAPY			
Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Maximum)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
PHYSICAL AND OCCUPATIONAL THERAPY			
Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Combined Maximum)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
HABILITATION THERAPY FOR CHILDREN THROUGH AGE 4			
Medically Necessary Services under age 5 (speech and occupational therapy)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
CHIROPRACTIC CARE			
26 Spinal Manipulations Per Year Maximum	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
ACUPUNCTURE			
Medically Necessary Acupuncture Services (20 Visits Per Year Maximum)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance

COVERED SERVICES	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
HEARING SERVICES			
Hearing Exam performed by an audiologist (1 Per Year Maximum)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 15% Coinsurance
Medically Necessary Hearing Aids up to $1,200 every 48 months	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
DURABLE MEDICAL EQUIPMENT			
Medically Necessary Equipment, Prosthetic Appliances, and Medical Supplies	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 15% Coinsurance
PRESCRIPTION DRUGS Using Participating Pharmacies in the Aetna National Pharmacy Network			
Covered drugs are evaluated and selected from Aetna's Standard Plan Formulary. Covered drugs require a written prescription and approval by FDA. Participating Pharmacy cost-sharing is detailed on this schedule. The Plan mandates Generic Substitution: Coverage is limited to cost of Generic when available. 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[2]. UVA Pharmacies include UVA at ERC, UVA Bookstore, UVA Student Health, Zion Crossroads, UVA Cancer Center Augusta, UVA Pantops, and UVA Specialty Pharmacies.	***Retail Pharmacy Network:*** Deductible & 20% for up to a ***30-day supply***. ***Maintenance Choice program[3]:*** Deductible & 20% for up to ***90-day supply*** through CVS Caremark Mail Service Pharmacy, UVA Pharmacy, and CVS Pharmacies. ***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. Limited Distribution Drugs may be filled through CVS Specialty Pharmacy:*** Deductible & 20%. Contraceptive drugs and devices are covered. OTC preventive items mandated by the federal health care reform law are covered with a prescription. Other OTC items are not covered.	***Retail Pharmacy Network:*** $6 (Generic), Deductible & 20% with $34 min/$150 max (Preferred brand), and Deductible & 20% with $68 min/$225 max (Non-preferred brand) cost sharing per prescription for up to a ***30-day supply***. ***When using UVA Pharmacies:*** $6 (Generic), Deductible & 20% with $150 max (Preferred brand), and Deductible & 20% with $225 max (Non-preferred brand) cost sharing per prescription for up to a ***30-day supply***. ***Maintenance Choice program[3]:*** $14 (Generic), Deductible & 15% with $75 min/$375 max (Preferred brand), and Deductible & 15% coinsurance with $150 min/$475 max (Non-preferred brand) cost sharing per prescription for up to ***90-day supply through CVS Caremark Mail Service Pharmacy, UVA pharmacies, and CVS pharmacies***. ***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. Limited Distribution Drugs may be filled through CVS Specialty Pharmacy:*** Deductible & 20% with $100 max (Generic), Deductible & 20% with $150 max (Preferred brand), and Deductible & 20% with $200 max (Non-preferred brand) cost sharing per prescription. 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.
	Diabetic drugs, insulin, and supplies: $0 (Generic), $34 (Preferred brand) for 30-day supply; $0 (Generic), $75 (Preferred brand) for a 90-day supply through Maintenance Choice. Non-preferred brand diabetic drugs, insulin, and supplies are subject to the standard non-preferred cost-share amounts.		

*Reduced cost-sharing is available for some services when participants enrolled in Value Health use the UVA Provider Network.

[1]All options will pay 100% of in-network preventive diagnostic, laboratory, and x-ray procedures. The plan coinsurance will be applied for in-network non-preventive diagnostic, laboratory, and x-ray procedures after the annual deductible has been met.

[2]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 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.

[3]Participants can opt out of the Maintenance Choice program for all their maintenance medications. Contact Aetna at 800-987-9072 before your third fill of maintenance medications and you can continue to fill a 30-day supply at your retail pharmacy at the regular retail cost-share amount.