University of Virginia Health Plan 2021 Schedule of Benefits Choice Health

Covered Services	In-Network ¹	Out-of-Network ²		
Annual Deductible	Applies to services and covered prescriptions that have coinsurance; not applicable to services or prescriptions that have copayments or to amounts above the allowable amount or to penalties. ³			
Individual	\$500	\$1,500		
Family	\$1,000	\$3,000		
Out-of-Pocket Maximum	Includes coinsurance, deductible, copayments, and covered prescriptions; not applicable to amounts above the allowable amount or penalties. ³			
Individual	\$5,500	\$11,000		
Family	\$11,000	\$22,000		
Plan Coinsurance	Applies to all expenses unless otherwise stated.			
	Deductible & 15%	Deductible & 35%		
Professional Services in Office of	or Outpatient			
Primary care physician (PCP) visit	Deductible & 15% coinsurance	Deductible & 35% coinsurance		
Specialty care visit	Deductible & 15% coinsurance	Deductible & 35% coinsurance		
Maternity visit (routine prenatal)	Plan pays 100% ⁴	Deductible & 35% coinsurance		
Outpatient Procedures	Deductible & 15% coinsurance	Deductible & 35% coinsurance		
Other associated charges	Deductible & 15% coinsurance	Deductible & 35% coinsurance		
Teladoc Consultations	Using Teladoc provider network	only		
Virtual access to doctors for general medicine, behavioral healthcare, dermatology, and caregiving	Deductible & 15% coinsurance	Not available		
Preventive Care and Immunizations				
Preventive general physical exam (PCP only)	Plan pays 100%	Not covered		
Preventive well child care (under age 7) (PCP only)	Plan pays 100%	Not covered		
Preventive diagnostic tests, laboratory services and X-ray procedures (non-urgent only)	Plan pays 100% ⁴	Not covered		
Routine cancer screenings	Plan pays 100% ⁴	Not covered		

University of Virginia Health Plan

Effective Date: 1/1/2021

Covered Services	In-Network ¹	Out-of-Network ²	
For common communicable diseases as per CDC guidelines excluding those used for foreign travel	Plan pays 100%	Not covered	
Urgent Care Center	Must be an unexpected illness where services are needed sooner than a routine doctor's visit.		
	Deductible & 15% coinsurance		
Emergency Room Services	Must be an emergency to receive benefits. If admitted, benefits will be processed under the hospital care benefits.		
Emergency room visit	Deductible & 20% coinsurance		
Other associated charges	Deductible & 20% coinsurance		
Inpatient Hospital			
Inpatient care (semi-private accommodations unless private accommodations are approved for medical reasons)	Deductible & 15% coinsurance	Deductible & 35% coinsurance	
Limitation on inpatient days	Unlimited		
Other associated charges	Deductible & 15% coinsurance	Deductible & 35% coinsurance	
Transplant Services	Using Aetna's Institutes of Excellence network only		
Inpatient services and other associated charges	Deductible & 15% coinsurance	Not available	
Bariatric Services	Using Aetna's Institutes of Quality network only		
Inpatient services and other associated charges	Deductible & 15% coinsurance	Not available	
Outpatient Hospital			
Outpatient procedures and other associated charges	Deductible & 15% coinsurance	Deductible & 35% coinsurance	
Early Intervention Services	Lifetime maximum of \$5,000 per covered member for all covered medical services		
Primary care physician (PCP) visit	Deductible & 15% coinsurance	Deductible & 35% coinsurance	
Specialty care visit	Deductible & 15% coinsurance	Deductible & 35% coinsurance	
Infertility Services	Lifetime maximum of \$15,000 for medical and Rx services per		
Comprehensive Infertility and Advanced Reproductive Technology	subscriber and their covered spouse; no coverage for dependent children		
Treatment after diagnosis	Deductible & 15% coinsurance	Deductible & 35% coinsurance	
Skilled Nursing Facility			
Skilled nursing/rehabilitation facility (180 days per year combined, maximum)	Deductible & 15% coinsurance	Deductible & 35% coinsurance	
Hospice Care			

Covered Services	In-Network ¹	Out-of-Network ²			
Inpatient and outpatient services	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Home Health Services	Home Health Services				
Medically necessary services approved by Claims Administrator (90 visits per year maximum)	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Ambulance Transportation					
Local ground or air transportation when medically necessary to and/or from a hospital	Deductible & 15% coinsurance	Deductible & 15% coinsurance			
Mental Health and Substance A	1				
Inpatient hospital and residential treatment	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Outpatient treatment	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Speech Therapy					
Medically necessary restorative services, non-developmental conditions (40 visits per year maximum)	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Physical and Occupational There	apy				
Medically necessary restorative services, non-developmental conditions (40 visits per year combined maximum)	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Habilitation Therapy for children	through age 4				
Medically necessary services under age 5 (speech and occupational therapy)	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Chiropractic Care					
Spinal manipulations (26 per year maximum)	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Acupuncture					
Medically necessary acupuncture services (20 visits per year maximum)	Deductible & 15% coinsurance	Deductible & 35% coinsurance			
Durable Medical Equipment					
Medically necessary equipment, prosthetic appliances and medical supplies	Deductible & 15% coinsurance	Deductible & 35% coinsurance			

Prescription Drugs

Covered drugs are evaluated and selected from Aetna's Standard Plan Formulary. They require a written prescription and approval by the FDA.

Participating pharmacy cost-sharing using Aetna National Pharmacy Network pharmacies is detailed on this schedule.

The Plan mandates generic substitution. Coverage is limited to the cost of the generic when available. When a generic equivalent exists for a brand name prescription, you 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.³

Maintenance drugs for chronic conditions must be filled through the Maintenance Choice program with Opt-Out. This program allows 90-day scripts of maintenance drugs to be filled at UVA and CVS Pharmacies and CVS Caremark Mail Service Pharmacy. You must opt-out of Maintenance Choice if you want to fill a 30-day script of maintenance drugs at other retail pharmacies.

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.

Retail Pharmacy	Up to 30-day supply	
Generic drugs	\$6 copay	\$6 copay
Preferred brand drugs	Deductible & 20% coinsurance (\$150 maximum)	Deductible & 20% coinsurance (\$34 minimum/\$150 maximum)
Non-preferred brand drugs	Deductible & 20% coinsurance (\$225 maximum)	Deductible & 20% coinsurance (\$68 minimum/\$225 maximum)
Maintenance Choice program with Opt-Out ⁶	90-day supply	CVS Caremark Mail Service Pharmacy and CVS Retail Pharmacies
Generic drugs	\$14 copay	\$14 copay
Preferred brand drugs	Deductible & 15% coinsurance (\$375 maximum)	Deductible & 15% coinsurance (\$75 minimum/\$375 maximum)
Non-preferred brand drugs	Deductible & 15% coinsurance (\$475 maximum)	Deductible & 15% coinsurance (\$150 minimum/\$475 maximum)

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University of Virginia Health Plan Effective Date: 1/1/2021

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Covered Drugs ³	UVA Pharmacies ⁵	Aetna National Pharmacy Network
Specialty Drugs must be filled through UVA Specialty Pharmacy (Limited Distribution Drugs can also be filled through CVS Specialty Pharmacy)	Up to 30-day supply	CVS Specialty Pharmacy (Limited Distribution Specialty Drugs only)
Generic drugs	Deductible & 20% coinsurance (\$100 maximum)	Deductible & 20% coinsurance (\$100 maximum)
Preferred brand drugs	Deductible & 20% coinsurance (\$150 maximum)	Deductible & 20% coinsurance (\$150 maximum)
Non-preferred brand drugs	Deductible & 20% coinsurance (\$200 maximum)	Deductible & 20% coinsurance (\$200 maximum)
Non-covered prescription drugs³ in the following drug classes:	100% coinsurance	100% coinsurance
Weight loss drugs		
Nutritional supplements		
Fertility drugs (oral and injectable) above the \$15,000 lifetime max		
Diabetic drugs, insulin, and supplies	30-day supply	90-day supply through Maintenance Choice
Generic drugs	\$0	\$0
Preferred brand drugs	\$34	\$75
Non-preferred brand drugs	Deductible & 20% coinsurance (\$68 minimum/\$225 maximum); through UVA Pharmacies, Deductible & 20% coinsurance (\$225 maximum)	Deductible & 15% coinsurance (\$150 minimum/\$475 maximum); through UVA Pharmacies, Deductible & 15% coinsurance (\$475 maximum)

Participants living outside the United States for 90 consecutive days or longer who complete a special Foreign Country Enrollment Form available from the UVA HR 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. Aetna Institutes of Excellence Network Providers must perform all transplant services. Aetna Institutes of Quality Network Providers must perform all bariatric service. Health services received in the U.S. must be provided by Aetna participating providers to be eligible for in-network benefits.

Out-of-network 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.

- 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 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.
- Choice Health 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.
- UVA Pharmacies include UVA Pharmacy, Emily Couric Clinical Cancer Center Pharmacy, UVA Bookstore Pharmacy, UVA Student Health Pharmacy, Zion Crossroads Pharmacy, and UVA Cancer Center Augusta Pharmacy.
- 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 costshare amount.