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Group Insurance Plan of Benefits for UVA J Visa Health Plan (Control #706455) administered by Aetna International®

Your Plan Effective Date: January 1, 2022

Eligibility Provision			
Employee	Must meet the eligibility requirements for J Visa holders employed by The University of Virginia.		
Dependent	Spouse, children up to age 26 end of the month, regardless of student status.		
	Outside U.S.	**Inside U.S. Preferred Benefits (In-Network)**	**Inside U.S. Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$500 per calendar year	$500 per calendar year	Not covered
Family Deductible	$1,000 per calendar year	$1,000 per calendar year	Not covered
Individual Payment Limit *(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the U.S.)*	$5,500 per calendar year	$5,500 per calendar year	Not covered
Family Payment Limit *(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the U.S.)*	$11,000 per calendar year	$11,000 per calendar year	Not covered
Lifetime Maximum	Unlimited		
Hospital Services			
Inpatient	20% after deductible	20% after deductible	Not covered
Outpatient	20% after deductible	20% after deductible	Not covered
Private Room Limit	The institution's semiprivate rate.	The institution's semiprivate rate.	Not applicable
Pre-certification Penalty *Pre-Certification for certain types of Non-Preferred care received inside the U.S. must be obtained to avoid a reduction in benefits paid for that care. Pre- Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required - excluded amount applied separately to each type of expense. Contact the service center to determine if pre-certification is needed for a procedure.*	No penalty	No penalty	Not applicable
Emergency Room *OON ER services will be applied to the in-network deductible and OOP max*	25% after deductible	25% after deductible	25% after deductible
Non-Emergency Use of the Emergency Room	25% after deductible	50% after deductible	Not covered
Urgent Care	20% after deductible	20% after deductible	Not covered
Non-Urgent Use of Urgent Care Provider	20% after deductible	50% after deductible	Not covered
Ambulance Services Emergency	20% after deductible	20% after deductible	20% after deductible
Ambulance Services Non-Emergency	20% after deductible	20% after deductible	Not covered

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Physician Services			
Physician Office Visit	20% after deductible	No charge after $30 copay	Not covered
Specialist Office Visit	20% after deductible	No charge after $50 copay	Not covered
Mental Health & Alcohol/Drug Abuse Services			
Mental Health Inpatient *Unlimited days per calendar year*	20% after deductible	20% after deductible	Not covered
Mental Health Outpatient *Unlimited visits per calendar year*	20% after deductible	No charge after $50 copay	Not covered
Substance Abuse Inpatient *Unlimited days per calendar year*	20% after deductible	20% after deductible	Not covered
Substance Abuse Outpatient *Unlimited visits per calendar year*	20% after deductible	No charge after $50 copay	Not covered
Preventive Care Services			
Routine Child Physical Exams *7 exams in the first 12 months of life, 3 exams in the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, and 1 exam per 12 months thereafter to age 22*	20% after deductible	No charge	Not covered
Routine Adult Physical Exams *1 exam every 12 months age 18 to 22, 1 exam every 12 months age 22 to 65, 1 exam every 12 months age 65 and older*	20% after deductible $1,000 calendar year maximum	No charge	Not covered
Routine Gynecological Exams *Includes 1 exam and pap smear per calendar year*	20% after deductible	No charge	Not covered
Routine Mammograms	20% after deductible	No charge	Not covered
Prostate Specific Antigen (PSA)	20% after deductible	No charge	Not covered
Routine Digital Rectal Exam (DRE)	20% after deductible	No charge	Not covered
Colorectal Cancer Screening *Recommended: For all members age 45 and older.*	20% after deductible	No charge	Not covered
Routine Hearing Exams *1 exam every 24 months*	20% after deductible	No charge	Not covered
Hearing Aids *1 hearing aid per ear to $1,000 maximum per ear every 3 years*	20% after deductible	20% after deductible	Not covered

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Other Services			
Skilled Nursing Facility *120 visits per calendar year*	20% after deductible	20% after deductible	Not covered
Hospice Care Facility Inpatient *30 days lifetime maximum*	20% after deductible	20% after deductible	Not covered
Hospice Care Facility Outpatient *Unlimited lifetime maximum*	20% after deductible	20% after deductible	Not covered
Home Health Care *120 visits per calendar year, includes Private Duty Nursing*	20% after deductible	20% after deductible	Not covered
Spinal Disorder Treatment *Unlimited visits per calendar year*	20% after deductible	20% after deductible	Not covered
Short Term Rehabilitation *(Includes coverage for Occupational, Physical and Speech Therapies; 60 combined visits per calendar year)*	20% after deductible	20% after deductible	Not covered
Diagnostic Outpatient X-ray	20% after deductible	20% after deductible	Not covered
Diagnostic Outpatient Lab	20% after deductible	20% after deductible	Not covered
Base Infertility Services *(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)*	20% after deductible	20% after deductible	Not covered
Durable Medical Equipment *Unlimited lifetime maximum*	20% after deductible	20% after deductible	Not covered
Allergy Testing	20% after deductible	No charge after $50 copay	Not covered
Allergy Serum & Injections	20% after deductible	20% after deductible	Not covered
Transplants *Unlimited lifetime maximum at Aetna Transplant Excellence Center only*	Not covered	20% after deductible	Not covered
Diabetics Supplies	20% after deductible	20% after deductible	Not covered
Autism	*Autism covered same as any other expense. Member cost sharing is based on the type of service performed and the place of service where it is rendered.*		

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	Outside U.S.	Inside U.S. Preferred Benefits (In-Network)	Inside U.S. Non-Preferred Benefits (Out-of-Network)
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply) Includes contraceptives*	20% after deductible	$20 copay per month supply (includes Mail Order Drugs)	Not covered
Formulary Brand Name Drugs *(365 day maximum supply) Includes contraceptives*	20% after deductible	$40 copay per month supply (includes Mail Order Drugs)	Not covered
Non Formulary Generic and Brand Name Drugs *(365 day maximum supply) Includes contraceptives*	20% after deductible	$70 copay per month supply (includes Mail Order Drugs)	Not covered
Specialty Drugs *(30 day maximum supply)*	Not covered	Covered through UVA Specialty Pharmacy only	Not covered
Add on Services			
24-Hour Nurse Line	Included	Included	Not applicable
Emergency Assistance Services *Global emergency evacuation services, unlimited calendar year maximum*	Included	Included	Not applicable
In Touch Care	Included	Included	Not applicable
International Maternity Management Program	Included	Included	Not applicable
Teladoc	Not Included	Included	Not applicable
Health Assessment	Included	Included	Not applicable

This plan of benefits is underwritten by Aetna Life Insurance Company.

This is only a brief summary of the benefits available. Some restrictions may apply.

If you have Maryland or Washington membership, a separate policy may be required. For more specific information about the coverage details, including limitations, exclusions and other plan requirements, please refer to the employee booklet (which will be provided near the time the plan becomes effective).

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Medical Plan Caveats	
Women's preventive and other preventive health benefits	*This plan includes coverage for women's preventive and other preventive health benefits to the extent required under the Affordable care act beginning with plan years starting on or after August 1, 2012. For plan years effective on or after January 1, 2017, this plan also includes coverage for benefits in accordance with the nondiscrimination provisions under Section 1557 of the Affordable Care Act.*
Payment Limits	*Payment limits apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage, deductibles and copays may be used to satisfy the payment limit. Precertification penalty are excluded from the payment limit.*
Calendar Year and Per Confinement Deductibles	*There is no cross-application between calendar year and per confinement deductibles. If a member is hospitalized, he or she must meet both per confinement and calendar year deductibles (as applicable) before the plan pays any benefits.*
Coverage Maximum (Days/Visits)	*Coverage maximums up to a certain number of days/visits per calendar year are reached by combining the Preferred and Non- Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).*
In-Network Deductible/Coinsurance	*In-Network - deductible and coinsurance may apply to pap smears, DRE tests and PSA tests if billed by an independent laboratory provider.*
Maternity Care	*Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and eligible dependents. Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.*
Ancillary Services	*For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level, and will be subject to reasonable and customary charges. Note that this payment method may apply to other providers.*
Chiropractic Visits	*Copayments and coinsurance for chiropractic visits are capped at 25% of the amount due to the chiropractor.*
*Payment for Non-Preferred Providers**	*We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays 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 out-of-network care.* *As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health 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 or hospital.* *When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.* *Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.* *You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site. This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.*

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