



UNIVERSITY *of* VIRGINIA

University of Virginia Health Plan
Summary Plan Description

For University of Virginia Health Plan Enrollees
Effective January 1, 2020

Your UVA Health Plan Benefits

The University of Virginia Health Plan (the UVA Health Plan or the Plan) offers three medical plan options to provide comprehensive care for you and your eligible dependents. You choose the coverage that best meets the needs of you and your family.

Use this book to get the information you need when you seek routine medical services, face a serious illness or injury, or need to fill a prescription. You will find information about who is eligible, what is covered and not covered, how to file a claim and what happens when you are no longer eligible for coverage.

The UVA Health Plan, offered by the University of Virginia (the University), is administered by Aetna Life Insurance Company and includes a prescription drug program administered by OptumRx. If you have questions or need help, contact the numbers shown on your ID card or refer to “[Contacts](#)” in this book, on page 3.

Medical Coverage at a Glance

The UVA Health Plan provides comprehensive medical coverage and prescription drug benefits. Here’s an overview of how the Plan works.

Feature	Overview
<i>Your options</i>	<p>The UVA Health Plan offers three medical plan options:</p> <ul style="list-style-type: none"> ▪ Value Health; ▪ Choice Health; and ▪ Basic Health. <p>All options provide prescription drug coverage. If you are enrolled in Value Health and your work location zip code is more than 50 miles from Charlottesville, you will automatically be enrolled in the Value Health Out-of-Area option.</p>
<i>How the UVA Health Plan works</i>	<p>Each Plan option provides coverage for the same broad range of services, including doctor visits, prescription drugs, hospitalizations, and surgery. How the Plan pays benefits depends on your Plan option, whether the service is covered by the Plan, and whether you receive care from an in-network or out-of-network provider.</p>
<i>The UVA Health Plan networks</i>	<p>You have the freedom to choose any doctor or other healthcare provider within the Aetna network, or outside the network. With the Value Health option, you receive the highest level of coverage when you use a provider in the UVA Provider network.</p> <p>To find an in-network provider, visit: www.aetna.com/docfind/custom/uva.</p>

Feature	Overview
<p><i>How the Plan options are the same</i></p>	<p>The Plan options share many features:</p> <ul style="list-style-type: none"> ▪ They cover the same broad range of services, including prescription drugs; ▪ Preventive care services (in-network) are covered at 100% with no deductible; ▪ You must satisfy an annual deductible before coverage begins for most services. Then, you and the Plan share the cost of covered services (coinsurance) up to the out-of-pocket maximum; ▪ Once you reach the Plan’s out-of-pocket maximum, the Plan pays for covered services in full for the remainder of the year; and ▪ You can elect coverage for you and your eligible dependents. <p>In addition, Aetna is the Plan Administrator for medical services and OptumRx is the Plan Administrator for prescription drug benefits.</p>
<p><i>What’s covered</i></p>	<p>The Plan offers 100% coverage for in-network eligible preventive care and immunizations and you do not need to meet your annual deductible first. You are covered for eligible in-network and out-of-network care for a broad range of healthcare services, including doctor visits, urgent and emergency care, hospitalization, home health services, and behavioral health.</p>
<p><i>Your cost for coverage</i></p>	<p>You share in the cost of coverage through payroll contributions or monthly premiums and for the cost of care through deductibles, copays, and coinsurance. In general, the more you pay for coverage through payroll contributions or monthly premiums, the less you will pay for the cost of the healthcare services you receive.</p>
<p><i>About the prescription drug program</i></p>	<p>Pharmacy benefits, managed by OptumRx, are part of the UVA Health Plan and prescription drugs are covered like any other covered medical expense. The Plan pays benefits for prescriptions filled at a UVA Pharmacy, UVA Specialty Pharmacy or other participating OptumRx providers. You can have your medications filled at a retail pharmacy or through OptumRx Home Delivery. Specialty drugs must be filled at the UVA Specialty Pharmacy.</p>

Contacts

When you have questions or need more information, here are some of the resources available to you.

Resource	Situation	How to Contact
UVA HR	Contact UVA HR when you: <ul style="list-style-type: none"> ▪ Have a qualified life event ▪ Need to report a change in your name, address, or telephone number 	Call: 434-243-3344 Email: askHR@virginia.edu
Aetna member services	Contact Member Services when you have: <ul style="list-style-type: none"> ▪ Questions about the Plan's medical benefits or a question about a claim 	Call: 800-987-9072 Visit: www.aetna.com
Aetna member website	Use your secure member website when you need: <ul style="list-style-type: none"> ▪ Eligibility or claim status information ▪ A replacement ID card ▪ Copies of claim forms ▪ Access to tools that help you manage your healthcare 	Visit: www.aetna.com
Aetna network portal	Use Aetna's Provider Search website to find: <ul style="list-style-type: none"> ▪ Providers within the Aetna network ▪ New enrollee information package ▪ Plan selection & cost estimator tool ▪ Institutes of Excellence, Institutes of Quality, Aetna national vaccine network 	Visit: www.aetna.com/docfind/custom/uva
OptumRx	Contact when you have: <ul style="list-style-type: none"> ▪ Questions about the Plan's prescription drug benefits 	Call: 877-629-3123 Visit: www.optumrx.com
UVA Specialty Pharmacy	Contact when you have: <ul style="list-style-type: none"> ▪ Questions about benefits for Specialty Drugs ▪ Where to find a UVA Specialty Pharmacy 	Call: 434-297-5500

Contents

YOUR UVA HEALTH PLAN BENEFITS	1
MEDICAL COVERAGE AT A GLANCE.....	1
CONTACTS	3
ABOUT THIS SUMMARY.....	9
YOUR RIGHTS AND RESPONSIBILITIES	10
PARTICIPANT BILL OF RIGHTS.....	10
YOUR RESPONSIBILITIES AS A PLAN PARTICIPANT	10
ELIGIBILITY AND ENROLLMENT.....	11
WHO IS ELIGIBLE.....	11
<i>Active Employees</i>	<i>11</i>
<i>Postdoctoral Fellows</i>	<i>12</i>
<i>Dependents</i>	<i>12</i>
<i>Adopted Children.....</i>	<i>13</i>
<i>Children Born by Gestational Surrogate.....</i>	<i>13</i>
<i>Qualified Medical Child Support Orders</i>	<i>13</i>
<i>Retirees</i>	<i>14</i>
<i>Survivors of Active Employees.....</i>	<i>14</i>
HOW TO ENROLL.....	14
<i>New Employees</i>	<i>15</i>
<i>Open Enrollment</i>	<i>15</i>
QUALIFIED LIFE EVENT CHANGES.....	15
<i>Special Enrollment Rights.....</i>	<i>17</i>
<i>Qualified Life Event Required Documentation</i>	<i>17</i>
FINALIZATION OF ENROLLMENT ELECTIONS.....	19
<i>New Employees</i>	<i>19</i>
<i>Open Enrollment</i>	<i>19</i>
<i>Qualified Life Events and Special Enrollments.....</i>	<i>19</i>
WHEN COVERAGE BEGINS	19
WHAT IF I LEAVE THE UNIVERSITY, THEN COME BACK?	20
HOW YOU PAY FOR COVERAGE.....	20
<i>Before-Tax Contributions and Social Security</i>	<i>20</i>
<i>Postdoctoral Fellow Premiums.....</i>	<i>20</i>
<i>Retiree and Survivor Premiums</i>	<i>21</i>
WHEN COVERAGE ENDS.....	21
LEAVES OF ABSENCE	22
<i>Family, Medical, and Military Leave Act</i>	<i>22</i>
<i>USERRA Military Leave.....</i>	<i>23</i>
<i>Paid Leave and Unpaid Leave</i>	<i>23</i>
CONTINUED COVERAGE FOR A DISABLED CHILD.....	23
CONTINUING PLAN COVERAGE UNDER COBRA	24
<i>Electing and Paying for COBRA Coverage</i>	<i>25</i>
<i>Notification Requirements</i>	<i>26</i>
<i>Notification of Your COBRA Rights.....</i>	<i>27</i>
<i>Address Changes</i>	<i>27</i>

WHEN COBRA ENDS	27
YOUR UVA MEDICAL COVERAGE OPTIONS	28
VALUE HEALTH SCHEDULE OF BENEFITS	28
VALUE HEALTH OUT-OF-AREA SCHEDULE OF BENEFITS.....	32
CHOICE HEALTH SCHEDULE OF BENEFITS.....	37
BASIC HEALTH SCHEDULE OF BENEFITS	41
PRESCRIPTION DRUG SCHEDULE OF BENEFITS — FOR VALUE HEALTH AND CHOICE HEALTH.....	45
PRESCRIPTION DRUG SCHEDULE OF BENEFITS — FOR BASIC HEALTH.....	46
HOW MEDICAL COVERAGE WORKS.....	47
HEALTH SAVINGS ACCOUNT (HSA) WITH BASIC HEALTH COVERAGE	48
<i>Eligibility</i>	48
THE PROVIDER NETWORK.....	49
PRECERTIFICATION.....	50
<i>When You Need to Precertify Care</i>	50
<i>If You Don't Precertify</i>	51
<i>High-tech Radiology Precertification</i>	51
IN AN EMERGENCY	51
<i>Examples of Medical Emergencies</i>	52
ADVANCED ILLNESS RESOURCES.....	52
TRANSPLANT AND SPECIAL MEDICAL CARE	52
SPECIAL PROGRAMS.....	53
<i>Discount Programs</i>	53
<i>Health Management Programs</i>	53
TOOLS.....	54
<i>Online Medical Provider Directory</i>	54
<i>Aetna Member Website</i>	54
<i>Informed Health® Line</i>	55
<i>ID Cards</i>	55
COORDINATION WITH OTHER PLANS	55
IF YOU HAVE OTHER COVERAGE	55
COORDINATION WITH MEDICARE	57
<i>When This Plan Is Primary</i>	58
<i>End-Stage Renal Disease</i>	58
<i>When Medicare Is Primary</i>	58
<i>When Eligibility for the Plan Ends</i>	58
<i>How Medicare Affects Your Plan Benefits</i>	59
WHAT IS COVERED	59
PREVENTIVE CARE	59
<i>Routine Physical Exams</i>	59
<i>Screening and Counseling Services</i>	60
<i>Routine Ob/Gyn Exams</i>	61
<i>Routine Cancer Screenings</i>	61
VISITS AND WALK-IN CLINICS	61
<i>Office Visits</i>	61
<i>Home Visits</i>	61
<i>Walk-In Clinics</i>	61

TELEMEDICINE	62
TELADOC	62
FAMILY PLANNING AND MATERNITY	62
<i>Contraception Services</i>	62
<i>Voluntary Sterilization</i>	63
<i>Basic Infertility Services</i>	63
<i>Comprehensive Infertility and Advanced Reproductive Technology (ART)</i>	
<i>Expenses</i>	63
<i>Maternity Care</i>	64
<i>Birth Center</i>	65
<i>Breastfeeding Support, Counseling and Supplies</i>	65
HOSPITAL CARE	65
<i>Pre-Admission Testing</i>	66
SURGERY	66
<i>Anesthesia</i>	67
<i>Bariatric Surgery</i>	67
<i>Oral Surgery</i>	67
<i>Outpatient Surgery</i>	68
<i>Reconstructive Surgery</i>	69
<i>Transgender Reassignment (Sex Change) Surgery</i>	69
TRANSPLANTS.....	70
<i>The Institutes of Excellence Network</i>	71
ALTERNATIVES TO HOSPITAL INPATIENT CARE	71
<i>Skilled Nursing Facility</i>	71
<i>Home Health Care</i>	71
<i>Hospice Care</i>	72
EMERGENCY AND URGENT CARE	73
<i>Emergency Care</i>	73
<i>Urgent Care</i>	73
<i>Ambulance</i>	73
OTHER COVERED EXPENSES.....	74
<i>Acupuncture</i>	74
<i>Autism Spectrum Disorder</i>	74
<i>Chemotherapy</i>	75
<i>Diabetic Equipment, Supplies, and Education</i>	75
<i>Diagnostic X-Ray and Laboratory</i>	75
<i>Durable Medical and Surgical Equipment</i>	75
<i>Early Intervention Services</i>	76
<i>Experimental or Investigational Services</i>	76
<i>Gene-based, cellular and other innovative therapies (GCIT)</i>	77
<i>Infusion Therapy</i>	78
<i>Nutritional Counseling</i>	78
<i>Outpatient Complex Imaging</i>	78
<i>Outpatient Radiology Services</i>	79
<i>Outpatient Short-Term Rehabilitation</i>	79
<i>Prosthetic Devices</i>	80
<i>Radiation Therapy</i>	80
<i>Spinal Manipulation</i>	80
WOMEN'S HEALTH PROVISIONS.....	81
<i>The Newborns' and Mothers' Health Protection Act</i>	81

<i>The Women’s Health and Cancer Rights Act</i>	81
BEHAVIORAL HEALTH CARE.....	81
<i>Treatment of Mental Disorders</i>	81
<i>Treatment of Substance Abuse</i>	82
WHAT IS NOT COVERED.....	83
GENERAL EXCLUSIONS.....	83
ADVANCED REPRODUCTIVE TECHNOLOGY (ART).....	85
ALTERNATIVE HEALTH CARE.....	85
BEHAVIORAL HEALTHCARE.....	86
BIOLOGICAL AND BIONIC.....	86
COSMETIC PROCEDURES.....	87
CRIMINAL ACTS.....	87
CUSTODIAL AND PROTECTIVE CARE.....	87
DENTAL CARE.....	88
EDUCATION AND TRAINING.....	88
FAMILY PLANNING AND MATERNITY.....	89
FOOT CARE.....	89
GOVERNMENT AND ARMED FORCES.....	89
HEALTH EXAMS.....	89
HOME AND MOBILITY.....	90
HOME HEALTH CARE.....	90
HOSPICE CARE.....	90
INFUSION THERAPY.....	91
ORAL SURGERY.....	91
OUTPATIENT SHORT-TERM REHABILITATION.....	91
PRESCRIPTION DRUGS.....	92
REPRODUCTIVE AND SEXUAL HEALTH.....	92
ROUTINE PHYSICAL EXAM.....	93
STRENGTH AND PERFORMANCE.....	93
TESTS AND THERAPIES.....	94
TRANSPLANTS.....	94
TRAVEL AND TRANSPORTATION.....	94
VISION, SPEECH AND HEARING.....	94
WEIGHT CONTROL SERVICES.....	95
OPTUMRX PRESCRIPTION DRUG PROGRAM.....	95
BENEFIT LEVELS.....	95
<i>Generic and Brand-Name Drugs</i>	95
<i>What is the Formulary?</i>	96
RETAIL PHARMACY.....	96
<i>Preferred Pharmacy</i>	96
<i>Non-Preferred Pharmacy</i>	96
MAIL ORDER PRESCRIPTIONS.....	96
PRIOR AUTHORIZATION.....	97
SPECIALTY DRUG MANAGEMENT PROGRAM.....	97
STEP THERAPY PROGRAM.....	97
QUANTITY MANAGEMENT PROGRAM.....	98
PREVENTIVE MEDICATIONS LIST.....	98
COVERED DRUGS.....	98

WHAT THE PRESCRIPTION DRUG PROGRAM DOES NOT COVER	98
DRUGS AVAILABLE UNDER THE DISCOUNT BENEFIT PRICE STRUCTURE.....	100
AETNA MEDICAL CLAIMS AND APPEALS	100
KEEPING RECORDS OF EXPENSES	100
FILING CLAIMS.....	101
<i>Physical Exams</i>	101
TIME FRAMES FOR CLAIM PROCESSING.....	101
<i>Urgent Care Claims</i>	101
<i>Other Claims (Pre-Service and Post-Service)</i>	101
<i>Predeterminations</i>	102
<i>Ongoing Course of Treatment</i>	102
HEALTH CLAIMS — STANDARD APPEALS	102
<i>Exhaustion of Internal Appeals Process</i>	103
<i>Full and Fair Review of Claim Determinations and Appeals</i>	103
HEALTH CLAIMS — VOLUNTARY APPEALS.....	104
<i>External Review</i>	104
<i>Request for External Review</i>	105
<i>Preliminary Review</i>	105
<i>Referral to ERO</i>	106
<i>Expedited External Review</i>	107
<i>Referral of Expedited Review to ERO</i>	107
CLAIM FIDUCIARY.....	107
COMPLAINTS.....	108
RECOVERY OF OVERPAYMENT.....	108
OPTUMRX PRESCRIPTION DRUG CLAIMS AND APPEALS	108
REVIEW OF AN ADVERSE BENEFIT DETERMINATION.....	108
REVIEW PROCEDURE.....	109
ADMINISTRATIVE INFORMATION	110
PLAN INFORMATION	110
PLAN DOCUMENTS.....	111
INTERPRETATION OF ELIGIBILITY RULES	111
FUTURE OF THE PLAN.....	111
NON-DISCRIMINATION.....	111
PRIVACY OF YOUR HEALTH INFORMATION	112
UNIVERSITY OF VIRGINIA’S PLAN’S COMMITMENT TO PRIVACY	112
<i>Information Subject to this Notice</i>	113
SUMMARY OF THE PLAN’S PRIVACY PRACTICES	113
<i>Detailed Notice of the Plan’s Privacy Policies — the Plan’s Uses and Disclosures</i>	114
YOUR HEALTH INFORMATION RIGHTS.....	117
PROTECTED HEALTH INFORMATION	119
DEFINED TERMS.....	123
SUMMARIES OF BENEFITS AND COVERAGE.....	143

About this Summary

This book, including the UVA Health Plan's Schedules of Benefits, constitutes the UVA Health Plan's Summary Plan Description (SPD) and Plan Document.

In this book, you will find the information you need to understand your UVA Health Plan benefits, including:

- What rights and responsibilities you have under the Plan;
- Who is eligible for coverage;
- How to enroll and when you are allowed to change the coverage you have chosen;
- When coverage starts and ends;
- What the Plan covers and does not cover;
- How to file a claim or appeal a claim decision; and
- Definitions of key terms.

In addition, be sure to refer to the "[Administrative Information](#)" on page 110 for key information about the administration of the Plan and "[Summary of the Plan's Privacy Practices](#)" on page 113 for the University's privacy policy. Finally, this book includes the Affordable Care Act's Summary of Benefits and Coverage (SBC) for each Plan option.

Please read this SPD carefully and refer to it when you need to understand how your medical benefits work. The SPD is the binding document for Plan Administration in any appeal process. If you have questions or need help, call Aetna or OptumRx at the number shown on your ID card or see "[Contacts](#)" on page 3.

This book outlines provisions of the University of Virginia Health Plan (UVA Health Plan) as of January 1, 2020. The University of Virginia reserves the right to change, amend, suspend, or terminate any or all of the benefits under the UVA Health Plan, in whole or in part, at any time and for any reason at its sole discretion.

The University of Virginia adopts this Plan Document as a description of the UVA Health Plan. This Plan Document replaces any prior statement of health coverages of the Plan, effective January 1, 2020. If any provisions of this Plan are contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Note that by adopting and maintaining the UVA Health Plan, the University of Virginia has not entered into an employment contract with any employee or UVA Health Plan participant. Nothing in the legal UVA Health Plan documents or this book gives any employee or UVA Health Plan participant the right to employment by the University of Virginia or to interfere with the University of Virginia's right to discharge any employee at any time.

Certain company, product, and service names mentioned herein may be trademarks of their respective companies.

Your Rights and Responsibilities

Participant Bill of Rights

- You have the right to receive information about the UVA Health Plan, the Plan’s services, practitioners and providers, and your rights and responsibilities as a Plan participant.
- You have the right to every consideration of confidentiality concerning your own claims for medical care.
- You have the right to expect your provider to inform you about your illness and treatment and to have the information explained or interpreted, as necessary.
- You have the right to make decisions about your plan of care prior to and during the course of treatment.
- You have the right to benefits for medically necessary services that are covered under the UVA Health Plan.
- You have the right to prompt and courteous replies to questions regarding access to care, medical benefits, and medical claims.
- You have the right to know what your healthcare benefits are and have this information provided to you in a language you can understand.
- You have the right to file an appeal for reconsideration of a decision or complaints about the Plan or the care provided by participating network providers. Furthermore, you have the right to be provided with a defined process for addressing complaints and appeals. Please see “[Aetna Medical Claims and Appeals](#)” on page 100 and “[OptumRx Prescription Drug Claims and Appeals](#)” on page 108 in this Summary Plan Description for that process.

Your Responsibilities as a Plan Participant

- You are responsible for asking questions when you do not understand information or instructions.
- You are responsible for knowing whether you are seeking care from a network provider or out-of-network provider. If you have any questions, you should contact the Claims Administrator at the phone number located on your ID card.
- If you receive services from an out-of-network provider, you will be responsible for ensuring that the Claims Administrator has authorized the services, if required, and to know if they are approved out-of-network or in-network so that you receive benefits at the maximum benefit level.
- You are responsible for verifying with the Claims Administrator that a provider has obtained any necessary precertification.
- You are responsible for ensuring your family members are aware of the correct procedures for accessing care before obtaining benefits through the UVA Health Plan.
- You are responsible for making all necessary cost sharing payments to providers as required and outlined in the appropriate Schedule of Benefits in this Summary Plan Description.

- You are responsible for notifying UVA HR of any change in contact information or dependent eligibility by completing the changes through the on-line benefit portal. If you or your dependents will reside outside the United States for more than 90 days, you must submit the Foreign Country Enrollment Form to UVA HR.
- You are responsible for giving your providers the complete information needed to care for you, including accurate information regarding your current healthcare coverage, and for following the agreed-upon plan of treatment.
- You are responsible for providing UVA HR with information related to other health insurance coverage you or your covered spouse or dependents may have.
- You are responsible for completing your on-line enrollment within 30 days of eligibility or mid-year qualifying events to enroll or make changes in the Plan. If the enrollment period is missed for newly eligible benefits, your benefit status for those benefits will default to “waived”.
- You are responsible for providing documentation and answering questions that verify eligibility at the request of the Plan Administrator.
- You are responsible for informing UVA HR when your dependents are no longer eligible for enrollment in the health plan. You are also responsible for reimbursing the Plan for the cost of any ineligible claims paid by the Plan for eligible or ineligible dependents.

Eligibility and Enrollment

This section describes who is eligible for coverage, how to enroll for coverage, and when coverage goes into effect.

Who Is Eligible

Active Employees

You are eligible to enroll in the Plan if you are employed by the University and you are:

- A full-time employee;
- A part-time employee who is scheduled to work at least 20 hours per week;
- A part-time medical center employee who has either signed a Flexible Staffing Agreement or is otherwise an eligible part-time employee as defined by the Medical Center; or
- A wage employee who has averaged at least 30 hours of service per week during their initial or standard 12-month measurement period:
 - The initial measurement period for wage employees begins on your date of hire and extends for 12 months (one-time measurement period).
 - The standard measurement period for wage employees is the 12-month period between October 3rd to October 2nd (measured each year of employment).

If you are eligible for the UVA Health Plan based on the above criteria, an administrative period after the appropriate measurement period provides your enrollment window for health benefits. Coverage will be offered to you for the 12-month stability period that follows the administrative period.

Keep in Mind

Leased and contract employees are not eligible for the Plan.

Eligible employees on leave should see “[Leaves of Absence](#)” on page 22 for coverage details.

Postdoctoral Fellows

You are eligible to enroll in the Plan if you are a postdoctoral fellow with a postdoctoral appointment at the University of Virginia.

Dependents

You may enroll your eligible dependents if you provide documentation confirming their eligibility. Your eligible dependents are:

- Your legally recognized spouse in the Commonwealth of Virginia who has no access to affordable healthcare coverage of minimum value through his/her employer.
- Your dependent children through the end of the month in which they turn age 26, including:
 - Your children by birth or adoption;
 - Children placed with you for adoption;
 - Children for whom you are the legal parent through a surrogate contract;
 - Stepchildren; and
 - Foster children.
- Unmarried, dependent children for whom you are the legal guardian with permanent custody unless either of the child’s biological parents also lives with you except when the biological parent(s) is (are) a minor who shares custody with you.

These legal dependents are eligible through the end of the month in which they turn age 26 if custody was awarded prior to the child’s 18th birthday, the child lives at home, and is declared as a dependent on your income tax return.

Coverage for a dependent disabled child may continue beyond the end of the month in which they turn 26 if;

- The child is permanently and totally disabled;
- The disability began before the child reached age 26;
- The application forms for disability status are requested from Aetna (the claims administrator), completed, returned, and approved PRIOR to the dependent’s 26th birthday;
- The child is unmarried, lives with you full-time in a regular parent-child relationship, does not have a full-time job eligible for benefits, and is declared on your income tax return; and
- The child has maintained continuous coverage under an employer-sponsored plan of the employee or the other natural/adoptive parent since the disability began.

What If My Spouse and I Both Work for the University of Virginia?

No one may be covered both as an employee and as a dependent on the UVA Health Plan, and no dependent may be covered by more than one employee. If you and your spouse are both eligible employees, you have these options:

- One of you may enroll as an employee and cover the other as a dependent
- You may each enroll as an employee. Only one of you may enroll your children as a dependent.

Adopted Children

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 30 days of the placement.

If you miss this 30-day deadline, you must wait until the next open enrollment to submit the request and documentation. The change will be effective the first of the following year.

Children Born by Gestational Surrogate

Coverage for your legal child birthed by a surrogate mother is effective on the date the child is born if you request coverage for the child in writing within 30 days of the birth.

If you miss this 30-day deadline, you must wait until the next open enrollment to submit the request and documentation. The change will be effective the first of the following year.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is a court order that requires a parent to provide healthcare benefits to one or more children. Coverage under the Plan can be extended to a child covered by a QMCSO if:

- Your child meets the definition of an eligible dependent under the Plan; and
- The University determines that the order is “qualified.”

Coverage under the QMCSO is not effective until after the date your coverage becomes effective.

Dependent Eligibility Audit

All newly enrolled and newly eligible dependents requesting enrollment in the UVA Health Plan must provide documentation to confirm their relationship to the employee. The required documentation is detailed on the UVA HR website at <https://hr.virginia.edu/>. The Plan has the obligation and the right to audit dependent eligibility from time to time to ensure that the Plan is administered according to the Summary Plan Description.

Retirees

You are eligible to enroll in the Plan as a retiree if

- You retired from the University; and
- You worked at the University of Virginia Academic Division or Medical Center for at least five consecutive years directly prior to your retirement; and
- You were eligible for enrollment in the Plan as an active employee on your last day as an active University employee (not including COBRA coverage); and
- Your last employer before retirement was the University of Virginia; and
- You are a retiring University employee eligible for a monthly annuity payment from Virginia Retirement System (VRS) and you begin to receive your annuity payments immediately upon retirement; or
- You are a retiring University employee eligible for a periodic benefit payment from the Medical Center Retirement Plan (MCRP) or Optional Retirement Plan (ORP) programs.

You are also eligible to enroll in the Plan as a disabled retiree if you are approved for long-term disability through the VSDP or other Employer-Sponsored disability plans, have applied for Social Security disability, and have five consecutive years of service at the University of Virginia Academic Division or Medical Center directly prior to your disability.

You may join the Retiree group even if you weren't enrolled in the Plan as an active employee as long as you were eligible for enrollment in the Plan as an active employee on your last day as an active University employee. You will only be eligible for single coverage.

Your eligible dependents that are enrolled under your plan on your last day as an active University employee may enroll under your Retiree coverage.

If You Do Not Enroll

If you do not enroll within 30 days of first becoming eligible as a retiree, you will not have another chance to enroll in the Plan.

Survivors of Active Employees

Your surviving spouse and/or dependents are eligible to enroll in the Plan as a survivor if you die while you are an active employee at the University and they were enrolled under your plan on your last day as an active University employee. Their enrollment under your employee plan will terminate on the last day of the month following the month in which you died if they elect to extend benefits for an additional month at the same tier level and Plan option.

How to Enroll

Participation in the Plan is usually not automatic; you must enroll in order to have the coverage of your choice. You and your dependents can enroll:

- Within 30 days of the date you become eligible for coverage;
- During the open enrollment period; or
- Within 30 days of a qualified life event.

Wage employees can enroll within the Wage Administrative Period associated with your 12- month measurement period.

Important Enrollment Reminders

- All requests for enrollment of spouses or children must include documentation confirming dependent eligibility.
- All retiree enrollments must be submitted within 30 days of your retirement date.
- All survivor enrollments must be submitted within 30 days of the termination of their coverage on your employee plan.

New Employees

As a new employee, you must enroll within 30 days of your hire date. If you do not enroll or waive coverage within this 30-day period, you will not be able to enroll until the next open enrollment period unless you have a qualified life event.

Open Enrollment

During the open enrollment period, you have a chance to review your coverage needs for the upcoming year and change your coverage choices, if necessary. The choices you make during open enrollment will be in effect for the following calendar year.

Qualified Life Event Changes

During the calendar year, you may add or drop dependents only when you have a qualified life event. You must submit an application in writing to UVA HR or through Workday if you are an active employee for any change prior to or within 30 days of the qualified life event. The change will be effective the first of the month following receipt of the application or Workday request and required documentation (see [“Qualified Life Event Required Documentation”](#) on page 17) but no earlier than the event date. If you miss this 30-day deadline, you must wait until the next open enrollment to submit the request and documentation. The change will be effective the first of the following year.

If you are dropping dependents because they are no longer eligible to be enrolled on your Plan, their coverage will end as of the date described in [“When Coverage Ends”](#) on page 21. You will be responsible for reimbursing the Plan for any payments made by the Plan for claims submitted for your ineligible dependents after the date their coverage ends. These reimbursements may be deducted from your paycheck.

Participants with ineligible dependents enrolled on their policy or those who owe reimbursement for the cost of any ineligible claims paid by the Plan for you or your dependents may receive disciplinary action up to and including employment termination.

Any retroactive premiums refunded to employees for ineligible dependents must have been paid within the same calendar year as the notification of ineligibility to UVA HR. Retroactive premiums paid in prior calendar years will be forfeited.

When You Have a Qualified Life Event

The change in coverage you request must be consistent with, and due to, the qualified life event.

Documentation must be submitted to confirm qualifying events (see “[Qualified Life Event Required Documentation](#)” on page 17). Documentation must also be submitted to confirm dependent eligibility.

Online requests by active employees must be made through Workday for academic and medical center employees.

A qualified life event does not allow you to change from one Plan option to any other Plan option.

The following are examples of qualified life events and the enrollment changes they allow. For more information, see “[Qualified Life Event Required Documentation](#)” on page 17 or visit <https://hr.virginia.edu/>.

Qualified Life Event	Enrollment Changes Allowed
<i>You get married</i>	<ul style="list-style-type: none"> ▪ Enroll your spouse and other eligible dependents; or ▪ Drop coverage for yourself
<i>You have a child by birth or adoption, or add a stepchild or foster child to your family</i>	Enroll the child and other eligible dependents
<i>You get divorced, your marriage is annulled, or a covered dependent dies</i>	Drop coverage for your ex-spouse or deceased dependent
<i>Your covered child reaches the maximum age for coverage</i>	Drop coverage for your child
<i>As the result of a change in your spouse’s or dependent’s employment, healthcare coverage is available under your spouse’s or dependent’s plan</i>	Drop coverage for you and any dependents who enroll in your spouse’s or dependent’s plan
<i>As the result of a change in your spouse’s or dependent’s employment, healthcare coverage under your spouse’s or dependent’s plan is lost or the cost of coverage will increase significantly</i>	Add coverage for you and/or any eligible dependents who lost the other coverage
<i>You move into or out of the Plan service area</i>	None
<i>You become eligible for Medicare or Medicaid</i>	Drop coverage for yourself

Special Enrollment Rights

There are certain Qualified Life Events that provide you with Special Enrollment Rights:

- For birth, adoption or placement for adoption, you can enroll yourself, the new child, as well as any other eligible dependents not already on your policy. If you make an application to add the child within 30 days of the event, the coverage for the child is retroactive to the date of birth or adoption and the premium change, if appropriate, is effective the first of the month in which the event occurs. The addition of other dependents to your policy will be effective the first of the month after the event date.
- For marriage, you can enroll yourself, your new spouse and any other eligible dependents not already on your policy if you make application within 30 days of the event. The coverage is effective the first of the month following the receipt of the enrollment request and documentation at UVA HR or through Workday but no earlier than the event date.
- An additional Special Enrollment Right is granted by a federal law known as HIPAA when eligibility is lost for other group health coverage or health insurance coverage such as when COBRA coverage is exhausted. Based on these events, you may enroll yourself, your spouse and/or your dependents that have lost other coverage within 30 days of the event. The coverage is effective the first of the month following receipt of the enrollment request and documentation at UVA HR or through Workday but no earlier than the event date.
- Loss of S-CHIP/Medicaid eligibility or provision of premium assistance by S-CHIP/Medicaid is an additional Special Enrollment Right. You may enroll yourself, your spouse, and/or your dependents who have lost eligibility for the government- provided coverage or who have become eligible for state assistance which provides help paying for Plan coverage within 60 days of the event date. The coverage is effective the first of the month following receipt of the enrollment request and documentation at UVA HR but no earlier than the event date. Contact UVA HR through Workday with your documentation for assistance with this special enrollment.

Qualified Life Event Required Documentation

You will need to submit documentation to UVA HR with your application to verify your qualified life event. Here is a summary of the documentation you should provide for each qualified life event.

Qualified Life Event	Required Documentation
<i>If you get married</i>	<ul style="list-style-type: none"> ▪ A copy of a state-issued marriage certificate received after the date of the ceremony with recorded file date; and ▪ A copy of the first and second pages of the employee’s most recent federal tax return that shows the dependent listed as “spouse” if the date of the ceremony occurred during the previous tax year or earlier. Page 2 of the tax return must include signatures or an e-file confirmation number. Mark out all financial information and the first five digits of all Social Security numbers.

Qualified Life Event	Required Documentation
<i>If you get divorced or your marriage is annulled</i>	A copy of portions of the court documents (e.g., divorce decree or annulment) with the: <ul style="list-style-type: none"> ▪ Names of both parties; ▪ Date of divorce; and ▪ Judge’s stamp or signature.
<i>The birth of a child</i>	A copy of the birth certificate or birth letter showing the employee as parent.
<i>The adoption or placement of adoption of a child</i>	A copy of court-approved adoption order, placement order or modified birth certificate showing the employee’s name as parent.
<i>Your employment status changes at UVA and affects your eligibility to participate in the UVA Health Plan</i>	No documentation is required when a UVA employee has the following employment status changes: <ul style="list-style-type: none"> ▪ Increase in hours from part-time to full-time; ▪ Reduction of hours; or ▪ Commencement or return from an unpaid leave of absence.
<i>Your spouse or child’s employment is terminated</i>	A document from the employer on the employer’s letterhead indicating the employment termination date and the date health coverage ended.
<i>Your spouse or child has an employment change that affects eligibility for benefits</i>	A document from the employer on the employer’s letterhead, indicating the date your spouse or child became eligible or ineligible for health coverage and the date coverage began or ended.
<i>Your spouse or child commenced or returned from an unpaid leave of absence</i>	A document from the employer on the employer’s letterhead, indicating the date your spouse or child began or ended an unpaid leave of absence and the date health coverage began or ended.
<i>You are no longer required to provide dependent coverage</i>	Submit a Department of Social Services Order to confirm that you are no longer responsible for providing health plan coverage for your child(ren).
<i>There is a change in legal custody</i>	Provide a copy of a court document showing the: <ul style="list-style-type: none"> ▪ Name of employee or spouse as responsible party; ▪ Date of the change of eligibility; ▪ Name(s) of minor child(ren); and ▪ Judge’s stamp or signature.
<i>You (or your dependent) is no longer entitled to government-sponsored coverage</i>	Provide government documents showing the entitlement to or loss of eligibility for government-sponsored programs such as Medicaid, S-CHIP, or TRICARE.

Qualified Life Event	Required Documentation
<p><i>There is a coverage or cost change of more than 20% with your spouse or child's other coverage.</i></p> <p><i>Note: If spouse's health coverage is still ACA affordable and of minimum value, this is not a consistent qualified life event.</i></p>	<p>Provide documents from the employer showing:</p> <ul style="list-style-type: none"> ▪ The effective date of the changes; and ▪ The changes in cost and/or coverage (including information about the before coverage/cost and after coverage/cost in order to confirm the type and percentage change).
<p><i>Your spouse or child dies</i></p>	<p>Provide a copy of the death certificate or obituary.</p>

Finalization of Enrollment Elections

During any enrollment period including new employee enrollment, open enrollment, Qualified Life Event Changes, or Special Enrollment periods, there is a specific period of time to make election/changes under Section 125 of the IRS code based on the event and time period listed above. No other enrollments or changes can be allowed until the next open enrollment or Qualified Life Event occurs.

New Employees

When making an election in Workday, you are provided an opportunity to print a confirmation of your election choices. If the confirmation does not reflect your chosen elections, immediately notify UVA HR of the error so they can correct the inaccurate election before deductions begin in your paycheck. All elections are final until the next open enrollment or Qualified Life Event occurs.

If no attempt has been made to elect health benefits within 30 days of your hire date, you will be defaulted to “waived” for your health coverage.

Open Enrollment

If you make any elections or changes during open enrollment, you are provided an opportunity to print a confirmation of your election choices. If the confirmation does not reflect your chosen elections, immediately notify UVA HR of the error so they can correct the inaccurate election. Once the open enrollment period closes, all elections are final until the next open enrollment or Qualified Event occurs.

Qualified Life Events and Special Enrollments

When making an election or change, you are provided an opportunity to print a confirmation of your election choices. If the confirmation does not reflect your chosen elections, immediately notify UVA HR of the error so they can correct the inaccurate election before deductions begin in your paycheck. All elections are final until the next open enrollment or Qualified Event occurs.

When Coverage Begins

When Plan coverage begins depends on when you and your dependents enroll:

- If you enroll when you first become eligible, coverage begins on the first of the month following your date of hire. If you are hired on the first of the month, coverage begins immediately.
- If you enroll during the open enrollment period, coverage begins on the following January 1.

- If you enroll because of a qualified life event, coverage begins on the first of the month following receipt of the enrollment request and documentation at UVA HR if the enrollment is received within 30 days of the event, but no earlier than the event date except births and adoptions. These changes are effective the date of the event if the enrollment is received within 30 days of the event and the premium change, if appropriate, is effective the first of the month in which the event occurs. If you miss the 30-day deadline, you must wait until the next open enrollment to submit the request and documentation.
- For wage employees, coverage begins on the first of the month following the Wage Administrative Period associated with your 12-month measurement period.

What If I Leave the University, Then Come Back?

When will your coverage begin if you come back to work for the University? It all depends on when you are re-hired.

- If you are re-hired in a benefit eligible position within 31 days of leaving the University and were enrolled in benefits upon separation, you have no break in coverage. You must enroll in the same benefits you had prior to your separation.
- If you are re-hired in a benefit eligible position greater than 31 days after your termination date, you are treated as a new employee. Coverage begins on the first of the month following your date of hire. If you are hired on the first of the month, coverage begins immediately.

How You Pay for Coverage

While you are an active employee, you share the cost of coverage under the Plan through payroll contributions. Your contribution is deducted from your pay on a before-tax basis.

Before-Tax Contributions and Social Security

Before-tax contributions come from your pay before federal income taxes, FICA (Social Security and Medicare) taxes, and most state and local income taxes are figured.

Because your taxes are calculated on a lower amount of taxable income, you pay less tax. This has the effect of reducing the cost of your coverage.

When you reduce the amount of your pay that is subject to Social Security taxes, you may also reduce your Social Security benefit. Any benefit reduction, however, should be only slight, and it will likely be more than offset by your reduced taxes.

For Information about the Taxation of Benefits

Consult your tax adviser if you have questions about your benefit contributions and taxes.

Postdoctoral Fellow Premiums

When you are a postdoctoral fellow, you are responsible for the monthly premium payments that are not covered by your grant or department. You can elect to receive coupons for monthly premium payments or arrange monthly electronic payments from your bank.

Self-payments are due on the first day of the month for which coverage is sought (the coverage period). If payment in full is not received within 30 days of the due date, the coverage will be cancelled with no option to reinstate coverage. If your premium is received after the due date but before the end of the 30-day grace period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the premium is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. Reimbursements for covered expenses incurred will only be made when all required self-payments have been received.

The premium rates charged for the postdoctoral fellow group and the benefits provided under the Plan are subject to change annually. Premium rates and benefits will generally not change more than once per year.

Requests for termination of your or your dependent's coverage will be granted prospectively. Retroactive termination requests and associated premium refunds will not be honored.

Retiree and Survivor Premiums

When you are a retiree or survivor, you are responsible for the monthly premium payments. You can elect to have the premium debited directly from your VRS annuity, receive coupons for monthly premium payments, or arrange monthly electronic payments from your bank.

Self-payments are due on the first day of the month for which coverage is sought (the coverage period). If payment in full is not received within 30 days of the due date, the coverage will be cancelled with no option to reinstate coverage. If your premium is received after the due date (but before the end of the 30-day grace period), your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the premium is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. Reimbursements for covered expenses incurred will only be made when all required self-payments have been received.

The premium rates charged for the retiree and survivor group and the benefits provided under the Plan are subject to change annually. Premium rates and benefits will generally not change more than once per year.

Requests for termination of your or your dependent's retiree or survivor coverage will be granted prospectively. Retroactive termination requests and associated premium refunds will not be honored.

When Coverage Ends

Plan coverage for an employee ends the last day of the month in which any of the following occurs:

- The employee no longer meets the Plan's eligibility requirements;
- The Plan is terminated;
- The employee dies;
- Employment ends;
- The employee fails to pay any required contribution for coverage or reimbursement for payment of ineligible claims; or
- The employee covers an ineligible dependent.

Coverage for dependents end on:

- The last day of the month in which:
 - The employee's coverage ends;
 - The dependent is no longer eligible for dependent coverage;
 - The employee does not pay the required contribution for dependent coverage;
 - The dependent dies;
 - All dependent coverage under the Plan ends;
 - The dependent becomes covered as an employee; or
 - The dependent child reaches age 26.
- The last day of the month after the month in which the employee dies.

Coverage for a retiree or survivor ends on the earliest of the following dates:

- The last day of the month in which a retiree or survivor waives coverage;
- The last day of the month preceding the first day of the month in which the retiree or survivor becomes eligible for Medicare;
- The last day of the month preceding the first day of the month for which the retiree or survivor fails to make a premium payment or repayment for ineligible claims, in full, when due;
- The last day of the month in which long-term disability payments end;
- The last day of the month in which a retiree or survivor no longer meets the Plan's eligibility requirements;
- The last day of the month in which a survivor remarries;
- The date the Plan is terminated or coverage for all retirees/survivors under the Plan is terminated; or
- The date of the retiree's or survivor's death.

In the event of a divorce, coverage for a spouse ends on the last day of the month of the divorce.

Leaves of Absence

The Plan includes rules about how a leave of absence affects your coverage. The rules vary based on the reason for the leave.

Family, Medical, and Military Leave Act

Through the Family and Medical Leave Act (FMLA), you may request up to 12 work weeks of leave during any 12-month period for the birth or adoption of a child, or for a serious health condition affecting you or a family member and up to 26 weeks for qualified military leave. During FMLA leave, your Plan coverage continues so long as you continue making your contributions.

USERRA Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) allows qualified employees to continue their enrollment in the Plan for up to 24 months when they are called to active duty for more than 31 days.

You may continue Plan coverage during your military leave until the earlier of:

- 24 months (terms are similar to COBRA); or
- The date you fail to return to work as outlined by USERRA.

If you do not continue coverage for you or your family members during your leave and you return to work:

- You and your family members will again be covered on the first of the month following the date you return to work from your military leave, if you apply at that time (this requires you to return to work as outlined by USERRA);
- Any eligibility waiting period not completed earlier will not be credited during your leave.

You will be given credit for the time you were covered under the Plan before your military leave, as well as credit for any/all of the 24-month continuation period, when elected.

You are responsible for paying the employee cost for coverage during a military leave. If you fail to make timely payments, as outlined in your billing statement, your coverage will be terminated. You must pay the billed amount in full; you cannot defer payments until you return to work.

Paid Leave and Unpaid Leave

The University and Medical Center policies describe several types of leave for several types of employee populations. Eligibility for health coverage, length of time health coverage is offered, and employee/employer premium costs vary depending on the leave type. For details on leave types, leave policies, and health coverage while on leave, visit <https://hr.virginia.edu/>, Time Off. You are responsible for paying your health premiums during your leave. If you fail to make timely payments as outlined in your billing statements, your coverage will be terminated. You must pay the billed amount in full; you cannot defer payments until you return to work.

Continued Coverage for a Disabled Child

When Plan coverage would normally end, your covered disabled dependent(s) may be able to continue coverage. This section describes how your disabled dependent may be able to continue coverage past the Plan's age limit for dependents.

Your child is considered disabled if:

- He or she is unable to earn a living because of a mental or physical disability that starts before he or she reaches the age limit for dependents; and
- He or she depends mainly on you for support and maintenance.

You must contact Aetna prior to your disabled dependent's 26th birthday and request the application forms for disability status. You and the child's treating physician must complete the forms giving proof of your child's disability, submit the forms, and be approved prior to your child's 26th birthday. The child must also be unmarried, live with you 100% of the time in a regular child-parent relationship, be claimed as a dependent on your income tax return, and not have a full-time job. The child's coverage will end on the first of the following to occur:

- Your child is no longer disabled;
- You fail to provide proof that the disability continues;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

Aetna has the right to require proof that the disability continues. Aetna also has the right to examine your child as often as needed while the disability continues. Once the child is two years beyond the Plan's dependent age limit, these exams will not be required more than once a year.

Continuing Plan Coverage under COBRA

When Plan coverage would normally end, you or your covered dependents may be able to temporarily continue coverage in certain circumstances. This section describes how you or your covered dependents may be able to continue coverage through the Consolidated Budget Reconciliation Act of 1985 (COBRA).

If your employment ends for any reason other than for gross misconduct, or if you or your covered dependent is no longer eligible for coverage under the Plan, you and/or your covered dependent may temporarily continue coverage through the federal law known as COBRA. Notify UVA HR immediately if you or your covered dependents experience a "COBRA Event" as defined in the following chart. You have 60 days from the date of the event to contact UVA HR to enroll for COBRA. UVA HR will inform their COBRA Administrator of your or your dependents' eligibility upon receiving notification from you. If you do not report the COBRA Event during this timeframe, you will lose your eligibility to continue under COBRA.

If you wish to choose this continued coverage, you must do so in writing to the COBRA Administrator within 60 days of the later of the date of the COBRA notification letter from the COBRA Administrator or the date of the COBRA event that ends your regular active employee coverage under the Plan. You pay the full cost of COBRA coverage, plus a 2% administration fee on an after-tax basis. The full cost of coverage is different from the contribution you pay while you are working for the University.

The chart below lists the reasons that coverage could end for you or your covered dependent. For each of those reasons, COBRA specifies the length of time that you may continue your Plan coverage.

Reason Coverage Ended (“COBRA Event”)	Maximum COBRA Continuation Period		
	You	Your Spouse	Your Child
<i>You lose coverage because of reduced work hours</i>	18 months	18 months	18 months
<i>Your employment terminated for any reason other than for gross misconduct</i>	18 months	18 months	18 months
<i>You or your covered dependent becomes eligible for Social Security disability benefits when you lost coverage under the Plan</i>	29 months	29 months	29 months
<i>You divorce</i>	N/A	36 months	36 months
<i>You become entitled to Medicare</i>	N/A	36 months	36 months
<i>Your child is no longer eligible (e.g., reaches age 26)</i>	N/A	N/A	36 months

Being eligible for Medicare at the time of your COBRA event does not prevent you from electing COBRA coverage for yourself.

Electing and Paying for COBRA Coverage

You pay the full cost of your Plan coverage when you elect COBRA coverage, plus a 2% administration fee. When you are eligible for COBRA coverage, you will be notified of its monthly cost. If you become eligible for Social Security disability benefits, the cost of COBRA coverage starting with the 19th month will be 150% of the Plan’s cost, plus a 2% administration fee.

When you are notified by the Plan’s COBRA Administrator that you are eligible for COBRA coverage, you will have 60 days to elect that coverage. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your coverage began (the date of your COBRA event). During the 60-day election period, the Plan will, upon request, notify healthcare providers of your right to elect COBRA coverage, retroactive to the date of your COBRA event. Actual coverage will not begin until your first payment is received.

On an ongoing basis, premium payments are due on the first day of the month for the upcoming coverage period. You will not receive reminders for unpaid premiums. If payment due is not received within 30 days of the due date, coverage will end. If your premium is received after the due date but before the end of the 30-day grace period, your coverage under the Plan will be suspended as of the first day of the coverage period. When payment is received, coverage will be retroactively reinstated back to the first day of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied. If so, you may have to resubmit your claim once coverage is reinstated.

Notification Requirements

COBRA Event	Notification Procedures	Who Must Take Action and When
<i>If you terminate employment</i>	The COBRA Administrator will send a COBRA notification letter to your last known address notifying you and your dependents of your right to continued coverage	You must send a written request for COBRA to the COBRA Administrator within 60 days of the later of the date of the letter of Notification or the date of your employment termination, or the date that Plan coverage would otherwise be lost, if later.
<i>If you reduce work hours</i>	The COBRA Administrator will send a COBRA notification letter to your last known address notifying you and your dependents of your right to continued coverage	You must send a written request for COBRA to the COBRA Administrator within 60 days of the later of the date of the letter of Notification or the date of your employment termination, or the date that Plan coverage would otherwise be lost, if later.
<i>Other COBRA events</i>	The covered employee or qualified beneficiary must notify UVA HR of certain COBRA events. Those events are: Employee's divorce or child's loss of dependent status under the Plan's terms	You must notify UVA HR within 60 days of the date of the COBRA event. Failure to notify within this timeframe results in the loss of the opportunity to elect COBRA.
<i>Specific Notice</i>	The COBRA Administrator will send a COBRA notification letter to the last known address of your ex-spouse in the case of divorce or your address for a child's loss of eligibility	The ex-spouse or ineligible dependent must elect COBRA within 60 days of the COBRA event (such as the date of divorce or the date of loss of dependent eligibility) or the date of the letter of Notification, or the date that Plan coverage would be otherwise lost, if later. Failure to notify within this timeframe results in the loss of the opportunity to elect COBRA.
<i>If you seek an extension of COBRA coverage due to disability</i>	You must notify the COBRA Administrator	You must notify within 60 days of any final determination by the Social Security Administration that the individual is disabled and within 18 months of the COBRA event. Failure to notify within this timeframe results in the loss of the opportunity to seek an extension.
<i>If you are no longer disabled</i>	You must notify the COBRA Administrator	You must notify within 30 days of notification by the Social Security Administration that the individual is no longer disabled.

Will my COBRA Coverage be the same as active employee coverage?

Yes. Any changes made to Plan for active employees will also apply to you under COBRA.

While you are covered by the Plan under COBRA:

- You have the same rights as any other eligible employee — including the right to change your coverage election during the open enrollment period.
- If you have another COBRA event or a qualified life event, as described in “[Qualified Life Event Changes](#)” on page 15, you may change your coverage election.
- If your dependent has another COBRA event while under the COBRA coverage period of 18 months, your dependent may qualify for an additional period of COBRA coverage, with the total COBRA coverage period limited to 36 months; you or your dependent must notify the COBRA administrator of the second COBRA event.

Notification of Your COBRA Rights

The Plan’s COBRA administrator will notify you by mail of your right to elect COBRA coverage when your COBRA event is a reduction in hours or termination of employment. The notice will give you instructions on how to continue your plan coverage.

If your covered dependents lose coverage because of a divorce or loss of dependent status, you or your covered dependents must notify the University within 60 days of the COBRA event so that COBRA coverage may be offered and election rights can be mailed.

To extend your COBRA coverage beyond 18 months because of eligibility for disability benefits from Social Security, notice of the Social Security Administration’s determination must be provided within 60 days after you receive it, and before the end of your initial 18-month continuation period.

The COBRA Administrator is:

Chard Snyder
6867 Cintas Blvd
Mason, OH 45040
800-982-7715

Address Changes

In order to protect your family’s rights, you should keep the COBRA Administrator informed of any changes in address for all family members.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown in the above chart if:

- You or your covered dependent becomes eligible for Medicare after electing COBRA;
- You or your covered dependent becomes covered under another group plan that does not restrict coverage for a pre-existing condition. If your new plan does have a restriction for pre-existing conditions:
 - Your COBRA continuation under this Plan can continue until the earlier of the following: pre-existing condition restriction ends under the other plan or you reach the end of the maximum continuation period for this Plan;

- You fail to make a premium payment in full when due; or
- The Plan terminates.

Requests for termination of your COBRA coverage prior to the date you or your dependent has been covered for the maximum continuation period will be granted prospectively. Retroactive termination requests and associated premium refunds will not be honored.

Your UVA Medical Coverage Options

In this section, you'll find more detailed information about the services and supplies covered by the Plan. It's important to remember that the Plan covers only services and supplies that are necessary to diagnose or treat an illness or injury. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this book.

The medical plan options cover the same services and include the same features. The options differ as to the benefit payable for each type of covered service.

These charts summarize the most common benefits available to you under the UVA Health Plan administered by Aetna and OptumRx.

Value Health Schedule of Benefits

The following chart summarizes your cost share for Value Health coverage:

Option Feature	UVA Provider Network/Aetna Network	Out-of-Network
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.*	
▪ Individual	\$800	\$1,600
▪ Family	\$1,600	\$3,200
Out-of-Pocket Maximum	Includes coinsurance, deductible, copayments, and covered prescriptions; not applicable to amounts above the allowable amount.*	
▪ Individual	\$5,500	\$11,000
▪ Family	\$11,000	\$22,000
Plan Coinsurance	Applies to all expenses unless otherwise stated.	
	Deductible & 20%	Deductible & 40%

* 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.

The following shows how Value Health pays benefits for covered services:

Covered Services	UVA Provider Network*	Aetna Network**	Out-of-Network***
Professional Service in Office or Outpatient			
<i>Primary care physician (PCP) visit</i>	\$25 copay	\$40 copay	Deductible & 40% coinsurance
<i>Specialty care visit</i>	\$50 copay	\$80 copay	Deductible & 40% coinsurance
<i>Maternity visit (routine prenatal)</i>	Plan pays 100%****		Deductible & 40% coinsurance
<i>Outpatient Procedures</i>	Deductible & 20% coinsurance		Deductible & 40% coinsurance
<i>Other associated charges</i>	Deductible & 20% coinsurance		Deductible & 40% coinsurance
Teladoc Consultations	Using Teladoc provider network only		
<i>Virtual access to doctors for general medicine, behavioral healthcare, dermatology and caregiving</i>	\$40 copayment		Not available
Preventive Care and Immunizations			
<i>Preventive general physical exam (PCP only)</i>	Plan pays 100%		Not covered
<i>Preventive well child care (under age 7) (PCP only)</i>	Plan pays 100%		Not covered
<i>Preventive diagnostic tests, laboratory services and X-ray procedures (non-urgent only)</i>	Plan pays 100%****		Not covered
<i>Routine cancer screenings</i>	Plan pays 100%****		Not covered
<i>For common communicable diseases as per CDC guidelines excluding those used for foreign travel</i>	Plan pays 100%		Not covered
Urgent Care	Must be an unexpected illness where services are needed sooner than a routine doctor's visit.		
<i>Urgent care center visit</i>	Deductible & 20% coinsurance		

Covered Services	UVA Provider Network*	Aetna Network**	Out-of-Network***
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 & 25% coinsurance		
Other associated charges	Deductible & 25% coinsurance		
Inpatient Hospital			
Inpatient care (semi-private accommodations unless private accommodations are approved for medical reasons)	Deductible & 20% coinsurance		Deductible & 40% coinsurance
Limitation on inpatient days	Unlimited		
Other associated charges	Deductible & 20% coinsurance		Deductible & 40% coinsurance
Transplant Services	Using Aetna's Institutes of Excellence network only		
Inpatient services and other associated charges	Deductible & 20% coinsurance		Not available
Bariatric Services	Using Aetna's Institutes of Quality network only		
Inpatient services and other associated charges	Deductible & 20% coinsurance		Not available
Outpatient Hospital			
Outpatient procedures and other associated charges	Deductible & 20% coinsurance		Deductible & 40% coinsurance
Early Intervention Services	Lifetime maximum of \$5,000 per covered member for all covered medical services		
Primary care physician (PCP) visit	\$25 copay	\$40 copay	Deductible & 40% coinsurance
Specialty care visit	\$50 copay	\$80 copay	Deductible & 40% 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 & 40% coinsurance
Skilled Nursing Facility			
Skilled nursing/rehabilitation facility (180 days per year combined maximum)	Deductible & 20% coinsurance		Deductible & 40% coinsurance

Covered Services	UVA Provider Network*	Aetna Network**	Out-of-Network***
Hospice Care			
<i>Inpatient and outpatient services</i>	Deductible & 20% coinsurance		Deductible & 40% coinsurance
Home Health Services			
<i>Medically necessary services approved by Claims Administrator (90 visits per year maximum)</i>	Deductible & 20% coinsurance		Deductible & 40% coinsurance
Ambulance Transportation			
<i>Local ground or air transportation when medically necessary to and/or from a hospital</i>	Deductible & 20% coinsurance		Deductible & 20% coinsurance
Mental Health and Substance Abuse Services			
<i>Inpatient hospital and residential treatment</i>	Deductible & 20% coinsurance		Deductible & 40% coinsurance
<i>Outpatient treatment</i>	\$25 copayment	\$40 copayment	Deductible & 40% coinsurance
Speech Therapy			
<i>Medically necessary restorative services, non-developmental conditions (40 visits per year maximum)</i>	\$40 copayment		Deductible & 40% coinsurance
Physical and Occupational Therapy			
<i>Medically necessary restorative services, non-developmental conditions (40 visits per year combined maximum)</i>	\$40 copayment		Deductible & 40% coinsurance
Habilitation Therapy for children through age 4			
<i>Medically necessary services, non-developmental conditions under age 5</i>	\$40 copayment		Deductible & 40% coinsurance
Chiropractic Care			
<i>Spinal manipulations (26 per year maximum)</i>	\$40 copayment		Deductible & 40% coinsurance

Covered Services	UVA Provider Network*	Aetna Network**	Out-of-Network***
Acupuncture			
Medically necessary acupuncture services (20 visits per year maximum)	\$40 copayment		Deductible & 40% coinsurance
Durable Medical Equipment			
Medically necessary equipment, prosthetic appliances and medical supplies	Deductible & 20% coinsurance		Deductible & 40% coinsurance

* View UVA’s custom docfind at www.aetna.com/docfind/custom/uva to identify providers in the UVA Provider Network. When searching geographically by zip code or city, choose ‘The University of Virginia Health Plan — UVA Provider Network’ as the Plan. When searching by provider name, look at the provider details to see if ‘The University of Virginia Health Plan — UVA Provider Network’ is one of the participating plans for the provider.

** 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.

****Value 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.

Value Health Out-of-Area Schedule of Benefits

If your work location zip code is more than 50 miles from Charlottesville, you will automatically be covered under this option if you enroll in Value Health. The Value Health Out-of-Area option provides the same level of coverage for in-network and out-of-network services as Value Health. The difference is that your in-network coverage is only through the Aetna network.

The following chart summarizes your cost share for Value Health Out-of-Area coverage:

Option Feature	In-Network	Out-of-Network
Annual Deductible	Applies to services and covered prescriptions that have coinsurance; not applicable to services or prescriptions that have a copayment or amounts above the allowable amount.*	
▪ Individual	\$800	\$1,600
▪ Family	\$1,600	\$3,200

Option Feature	In-Network	Out-of-Network
Out-of-Pocket Maximum	Includes coinsurance, deductible, copayments, and covered prescriptions; not applicable to amounts above the allowable amount.*	
▪ Individual	\$5,500	\$11,000
▪ Family	\$11,000	\$22,000
Plan Coinsurance	Applies to all expenses unless otherwise stated.	
	Deductible & 20%	Deductible & 40%

* 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.

The following shows how Value Health Out-of-Area pays benefits for covered services:

Covered Services	In-Network*	Out-of-Network**
Professional Services in Office or Outpatient		
<i>Primary care physician (PCP) visit</i>	\$25 copay	Deductible & 40% coinsurance
<i>Specialty care visit</i>	\$50 copay	Deductible & 40% coinsurance
<i>Maternity visit (routine prenatal)</i>	Plan pays 100%***	Deductible & 40% coinsurance
<i>Outpatient Procedures</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
<i>Other associated charges</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Teladoc Consultations	Using Teladoc provider network only	
<i>Virtual access to doctors for general medicine, behavioral healthcare, dermatology and caregiving</i>	\$25 copayment	Not available

Covered Services	In-Network*	Out-of-Network**
Preventive Care and Immunizations		
<i>Preventive general physical exam (PCP only)</i>	Plan pays 100%	Not covered
<i>Preventive well child care (under age 7) (PCP only)</i>	Plan pays 100%	Not covered
<i>Preventive diagnostic tests, laboratory services and X-ray procedures (non-urgent only)</i>	Plan pays 100%***	Not covered
<i>Routine cancer screenings</i>	Plan pays 100%***	Not covered
<i>For common communicable diseases as per CDC guidelines excluding those used for foreign travel</i>	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 & 20% coinsurance	
Emergency Room Services	Must be an emergency to receive benefits. If admitted, benefits will be processed under the hospital care benefits.	
<i>Emergency room visit</i>	Deductible & 25% coinsurance	
<i>Other associated charges</i>	Deductible & 25% coinsurance	
Inpatient Hospital		
<i>Inpatient care (semi-private accommodations unless private accommodations are approved for medical reasons)</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
<i>Limitation on inpatient days</i>	Unlimited	
<i>Other associated charges</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Transplant Services	Using Aetna's Institutes of Excellence network only	
<i>Inpatient services and other associated charges</i>	Deductible & 20% coinsurance	Not available
Bariatric Services	Using Aetna's Institutes of Quality network only	
<i>Inpatient services and other associated charges</i>	Deductible & 20% coinsurance	Not available
Outpatient Hospital		
<i>Outpatient procedures and other associated charges</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance

Covered Services	In-Network*	Out-of-Network**
Early Intervention Services	Lifetime maximum of \$5,000 per covered member for all covered medical services	
<i>Primary care physician (PCP) visit</i>	\$25 copay	Deductible & 40% coinsurance
<i>Specialty care visit</i>	\$50 copay	Deductible & 40% coinsurance
Infertility Services <i>Comprehensive Infertility and Advanced Reproductive Technology</i>	Lifetime maximum of \$15,000 for medical and Rx services per subscriber and their covered spouse; no coverage for dependent children	
<i>Treatment after diagnosis</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Skilled Nursing Facility		
<i>Skilled nursing/rehabilitation facility (180 days per year combined maximum)</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Hospice Care		
<i>Inpatient and outpatient services</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Home Health Services		
<i>Medically necessary services approved by Claims Administrator (90 visits per year maximum)</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Ambulance Transportation		
<i>Local ground or air transportation when medically necessary to and/or from a hospital</i>	Deductible & 20% coinsurance	Deductible & 20% coinsurance
Mental Health and Substance Abuse Services		
<i>Inpatient hospital and residential treatment</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
<i>Outpatient treatment</i>	\$25 copayment	Deductible & 40% coinsurance
Speech Therapy		
<i>Medically necessary restorative services, non-developmental conditions (40 visits per year maximum)</i>	\$40 copayment	Deductible & 40% coinsurance

Covered Services	In-Network*	Out-of-Network**
Physical and Occupational Therapy		
Medically necessary restorative services, non-developmental conditions (40 visits per year combined maximum)	\$40 copayment	Deductible & 40% coinsurance
Habilitation Therapy for children through age 4		
Medically necessary services, non-developmental conditions under age 5	\$40 copayment	Deductible & 40% coinsurance
Chiropractic Care		
Spinal manipulations (26 per year maximum)	\$40 copayment	Deductible & 40% coinsurance
Acupuncture		
Medically necessary acupuncture services (20 visits per year maximum)	\$40 copayment	Deductible & 40% coinsurance
Durable Medical Equipment		
Medically necessary equipment, prosthetic appliances and medical supplies	Deductible & 20% coinsurance	Deductible & 40% coinsurance

* 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. 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.

** 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.

***Value Health Out-of-Area 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.

Choice Health Schedule of Benefits

The following chart summarizes your cost share for Choice Health coverage:

Option Feature	Aetna Network	Out-of-Network
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.*	
▪ 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.*	
▪ Individual	\$5,500	\$11,000
▪ Family	\$11,000	\$22,000
Plan Coinsurance	Applies to all expenses unless otherwise stated.	
	Deductible & 15%	Deductible & 35%

* 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.

The following shows how Choice Health pays benefits for covered services:

Covered Services	In-Network*	Out-of-Network**
Professional Services in Office 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)	Play pays 100%***	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 annual including behavioral healthcare, dermatology and caregiving	Deductible & 15% coinsurance	Not available

Covered Services	In-Network*	Out-of-Network**
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%***	Not covered
Routine cancer screenings	Plan pays 100%***	Not covered
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

Covered Services	In-Network*	Out-of-Network**
Early Intervention Services	Lifetime maximum of \$5,000 per covered member for all covered medical services	
<i>Primary care physician (PCP) visit</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Specialty care visit</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
Infertility Services <i>Comprehensive Infertility and Advanced Reproductive Technology</i>	Lifetime maximum of \$15,000 for medical and Rx services per subscriber and their covered spouse; no coverage for dependent children	
<i>Treatment after diagnosis</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
Skilled Nursing Facility		
<i>Skilled nursing/rehabilitation facility (180 days per year combined, maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
Hospice Care		
<i>Inpatient and outpatient services</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
Home Health Services		
<i>Medically necessary services approved by Claims Administrator (90 visits per year maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
Ambulance Transportation		
<i>Local ground or air transportation when medically necessary to and/or from a hospital</i>	Deductible & 15% coinsurance	Deductible & 15% coinsurance
Mental Health and Substance Abuse Services		
<i>Inpatient hospital and residential treatment</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Outpatient treatment</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
Speech Therapy		
<i>Medically necessary restorative services, non-developmental conditions (40 visits per year maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance

Covered Services	In-Network*	Out-of-Network**
Physical and Occupational Therapy		
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, non-developmental conditions under age 5	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

* 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.

***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.

Basic Health Schedule of Benefits

The following chart summarizes your cost share for Basic Health coverage.

See HSA rules before enrolling in this Plan Option: <https://hr.virginia.edu/benefits/benefit-savings-accounts/health-savings-account>.

Option Feature	Aetna Network	Out-of-Network
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.*	
▪ Employee Only Coverage**	\$2,000	\$6,000
▪ Employee + Child(ren), Employee + Spouse, or Family Coverage**	\$4,000	\$12,000
Out-of-Pocket Maximum	Includes coinsurance, deductible, copayments, and covered prescriptions; not applicable to amounts above the allowable amount.*	
▪ Individual	\$4,000	\$8,000
▪ Family	\$8,000	\$16,000
Plan Coinsurance	Applies to all expenses unless otherwise stated.	
	Deductible & 20%	Deductible & 40%

* 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.

** There is no individual deductible for Basic Health participants. Those with Employee Only coverage have a \$2,000 in-network deductible. When more than one participant in a family is covered, the full \$4,000 in-network deductible must be met before claims can be paid. This deductible can be met by one family member satisfying the entire \$4,000 deductible or by multiple family members totaling their eligible claims to satisfy the \$4,000 deductible.

The following shows how Basic Health pays benefits for covered services:

Covered Services	In-Network*	Out-of-Network**
Professional Services in Office or Outpatient		
Primary care physician (PCP) visit	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Specialty care visit	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Maternity visit (routine prenatal)	Play pays 100%***	Deductible & 40% coinsurance
Outpatient Procedures	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Other associated charges	Deductible & 20% coinsurance	Deductible & 40% coinsurance

Covered Services	In-Network*	Out-of-Network**
Teladoc Consultations	Using Teladoc provider network only	
<i>Virtual access to doctors for general including behavioral healthcare dermatology and caregiving.</i>	Deductible & 20% coinsurance	Not available
Preventive Care and Immunizations		
<i>Preventive general physical exam (PCP only)</i>	Plan pays 100%	Not covered
<i>Preventive well child care (under age 7) (PCP only)</i>	Plan pays 100%	Not covered
<i>Preventive diagnostic tests, laboratory services and X-ray procedures (non-urgent only)</i>	Plan pays 100%***	Not covered
<i>Routine cancer screenings</i>	Plan pays 100%***	Not covered
<i>For common communicable diseases as per CDC guidelines excluding those used for foreign travel</i>	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 & 20% coinsurance	
Emergency Room Services	Must be an emergency to receive benefits. If admitted, benefits will be processed under the hospital care benefits.	
<i>Emergency room visit</i>	Deductible & 25% coinsurance	
<i>Other associated charges</i>	Deductible & 25% coinsurance	
Inpatient Hospital		
<i>Inpatient care (semi-private accommodations unless private accommodations are approved for medical reasons)</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
<i>Limitation on inpatient days</i>	Unlimited	
<i>Other associated charges</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Transplant Services	Using Aetna's Institutes of Excellence network only	
<i>Inpatient services and other associated charges</i>	Deductible & 20% coinsurance	Not available
Bariatric Services	Using Aetna's Institutes of Quality network only	
<i>Inpatient services and other associated charges</i>	Deductible & 20% coinsurance	Not available

Covered Services	In-Network*	Out-of-Network**
Outpatient Hospital		
<i>Outpatient procedures and other associated charges</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Early Intervention Services	Lifetime maximum of \$5,000 per covered member for all covered medical services	
<i>Primary care physician (PCP) visit</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
<i>Specialty care visit</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Infertility Services <i>Comprehensive Infertility and Advanced Reproductive Technology</i>	Lifetime maximum of \$15,000 for medical and Rx services per subscriber and their covered spouse; no coverage for dependent children	
<i>Treatment after diagnosis</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Skilled Nursing Facility		
<i>Skilled nursing/rehabilitation facility (180 days per year combined maximum)</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Hospice Care		
<i>Inpatient and outpatient services</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Home Health Services		
<i>Medically necessary services approved by Claims Administrator (90 visits per year maximum)</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Ambulance Transportation		
<i>Local ground or air transportation when medically necessary to and/or from a hospital</i>	Deductible & 20% coinsurance	Deductible & 20% coinsurance
Mental Health and Substance Abuse Services		
<i>Inpatient hospital and residential treatment</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
<i>Outpatient treatment</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Speech Therapy		
<i>Medically necessary restorative services, non-developmental conditions (40 visits per year maximum)</i>	Deductible & 20% coinsurance	Deductible & 40% coinsurance

Covered Services	In-Network*	Out-of-Network**
Physical and Occupational Therapy		
Medically necessary restorative services, non-developmental conditions (40 visits per year combined maximum)	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Habilitation Therapy for children through age 4		
Medically necessary services, non-developmental conditions under age 5	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Chiropractic Care		
Spinal manipulations (26 per year maximum)	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Acupuncture		
Medically necessary acupuncture services (20 visits per year maximum)	Deductible & 20% coinsurance	Deductible & 40% coinsurance
Durable Medical Equipment		
Medically necessary equipment, prosthetic appliances and medical supplies	Deductible & 20% coinsurance	Deductible & 40% coinsurance

* 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.

***Basic 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.

Prescription Drug Schedule of Benefits – for Value Health and Choice Health

This chart summarizes the pharmacy benefits available through the OptumRx prescription benefit program, which is available with Value Health and Choice Health. Coverage is available when you purchase your prescriptions through participating pharmacies.

Covered drugs are evaluated and selected from OptumRx’s Premium Formulary. They require a prescription and approval by the FDA. Participating pharmacy cost sharing is detailed on the schedule below. The Plan mandates generic substitution. Coverage is limited to 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.

Combined Medical and Rx Deductible

The Value Health and Choice Health deductible applies to both covered medical and prescription drug expenses.

Prescription Drugs*	UVA Pharmacies**	OptumRx Pharmacy Network
Retail Pharmacy	Up to 30-day supply***	
<i>Tier 1 (most generic drugs and some cost-effective brand-name drugs)</i>	\$6 copay	\$6 copay
<i>Tier 2 (most brand-name drugs and some more costly or less desirable generic drugs)</i>	Deductible & 20% coinsurance (\$150 maximum)	Deductible & 20% coinsurance (\$34 minimum/\$150 maximum)
<i>Tier 3 (non-preferred brand-name drugs and some more costly generic drugs)</i>	Deductible & 20% coinsurance (\$225 maximum)	Deductible & 20% coinsurance (\$68 minimum/\$225 maximum)
Mail-Order Prescription Drugs	31 to 90-day supply	
<i>Tier 1 (most generic drugs and some cost-effective brand-name drugs)</i>	Not available	\$14 copay
<i>Tier 2 (most brand-name drugs and some more costly or less desirable generic drugs)</i>	Not available	Deductible & 15% coinsurance (\$75 minimum/\$375 maximum)
<i>Tier 3 (non-preferred brand-name drugs and some more costly generic drugs)</i>	Not available	Deductible & 15% coinsurance (\$150 minimum/\$475 maximum)

Prescription Drugs*	UVA Pharmacies**	OptumRx Pharmacy Network
Specialty Drugs****	Up to 30-day supply	
<i>Tier 1 (most biosimilar drugs and some cost-effective brand-name drugs)</i>	20% coinsurance (\$100 maximum)	Not available
<i>Tier 2 (most brand-name drugs and some more costly biosimilar drugs)</i>	20% coinsurance (\$150 maximum)	Not available
<i>Tier 3 (non-preferred brand-name drugs)</i>	20% coinsurance (\$200 maximum)	Not available

* 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.

** UVA Pharmacies include UVA Pharmacy, Emily Couric Clinical Cancer Center Pharmacy, UVA Bookstore Pharmacy, Zion Crossroads Pharmacy, UVA Cancer Center August Pharmacy, and UVA Specialty Pharmacy.

*** A 31 to 90-day supply may be purchased at participating retail pharmacies with no discounted copayment.

**** Specialty drugs must be filled through UVA Specialty Pharmacy in order to be covered.

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 noncovered drugs does not count towards the deductible or out-of-pocket maximum.

Prescription Drug Schedule of Benefits – for Basic Health

This chart summarizes the pharmacy benefits available through the OptumRx prescription benefit program, which is available with Basic Health. Coverage is available when you purchase your prescriptions through participating pharmacies.

Covered drugs are evaluated and selected from Optum’s Premium Formulary. They require a prescription and approval by the FDA. Participating pharmacy cost sharing is detailed on the schedule below. 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.

Combined Medical and Rx Deductible

The Basic Health deductible applies to both covered medical and prescription drug expenses.

Prescription Drugs*	UVA Pharmacies**	OptumRx Pharmacy Network
Retail Pharmacy	Up to 90-day supply	
	Deductible & 20% coinsurance	Deductible & 20% coinsurance
OptumRx Home Delivery	90-day supply	
	Not available	Deductible & 20% coinsurance
Specialty Drugs***	Up to 30-day supply	
	Deductible & 20% coinsurance	Not available

* 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.

** UVA Pharmacies include UVA Pharmacy, Emily Couric Clinical Cancer Center Pharmacy, UVA Bookstore Pharmacy, Zion Crossroads Pharmacy, UVA Cancer Center August Pharmacy, and UVA Specialty Pharmacy.

***Specialty drugs must be filled through UVA Specialty Pharmacy in order to be covered.

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 noncovered drugs does not count towards the deductible or out-of-pocket maximum.

How Medical Coverage Works

The UVA Health Plan offers the following medical plan options:

- Basic Health;
- Choice Health; and
- Value Health.

All of the options provide coverage for the same broad list of covered services, including in-network preventive care at 100% and prescription drug coverage. In addition, they all allow you the flexibility to use in-network and out-of-network providers. The options differ in the amount you pay for coverage (your premium contributions) and the amounts you pay when you need care.

The Basic Health option has the lowest cost per pay period, but the annual deductibles are the highest. Because this plan qualifies as a high deductible health plan (HDHP), it enables you to participate in a special tax-advantaged Health Savings Account (HSA) which is available only to Basic Health participants. You must be eligible for, and enrolled in, an HSA in order to enroll in the Basic Health option.

The Choice Health option has the highest cost per pay period, but also has the lowest out-of-pocket costs when you need care. With Value Health, you receive the highest coverage when you use providers who participate in the UVA network.

This section describes important features of the Plan. Refer to the Schedule of Benefits (see “[Your UVA Medical Coverage Options](#)” on page 28) for specific coverage levels for each option. An out-of-area option for Value Health is available to employees whose work location zip code is more than 50 miles from Charlottesville.

You must be covered by the Plan on the date you incur a covered medical expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends. There are no pre-existing condition exclusions.

About Basic Health

Postdoctoral Fellows and Housestaff are not eligible to enroll in Basic Health. Basic Health is the only health option available for wage employees. The employer does not provide HSA contributions to wage employees.

Health Savings Account (HSA) with Basic Health Coverage

When you enroll in Basic Health, you must also enroll in a special tax-advantaged Health Savings Account (HSA). The HSA allows you to set aside funds on a pre-tax basis up to the annual IRS maximum contribution limit. In addition, UVA has the discretion to contribute to an employee's HSA depending upon their employment classification. See details on Health Savings Accounts (HSAs) at <https://hr.virginia.edu/>.

You can use your HSA to pay for qualified medical expenses which generally include your medical deductible, coinsurance payments, and prescription drug expenses. Or, you may pay for your expenses out of pocket and let your account grow and earn interest for future expenses. Since account balances roll over from year to year, your account can accumulate over time.

Your account is portable. If you retire or leave the University for any reason, you take the balance of your HSA with you. Note that it is your responsibility to manage your annual contributions per the annual IRS limits. It is also your responsibility to reconcile any amounts over the annual limit when filing taxes.

Eligibility

You must be eligible for, and enrolled in, an HSA in order to enroll in the Basic Health option.

You are not eligible for an HSA if:

- You hold a J-1 visa;
- You are enrolled in Medicare or Medicaid or are listed as a dependent on someone else's tax return;
- You or your spouse have a balance in a healthcare FSA, are part of an FSA grace period, or your plan year is not over;
- You received healthcare benefits from the Veterans Administration (TRICARE) within the last three months;
- You have a spouse or parent who is enrolled in a healthcare plan (including a Health Reimbursement Account) that provides you with benefits before meeting the IRS minimum deductible; and
- You already contributed the annual federally-set limit to another HSA, Medical Savings Account (MSA), or HRA in the same calendar year.

The Provider Network

If you enrolled in Value Health, Choice Health, or Basic Health, you have the freedom to choose any doctor or other healthcare provider when you need medical care. How that care is covered and how much you pay out of your own pocket depends on whether the expense is covered by the Plan and whether you choose an in-network provider or an out-of-network provider.

Special UVA Preferred Provider Network with Value Health

When you are enrolled in Value Health and use a provider in the UVA Provider network, the Plan pays the highest level. That means you pay less out of your own pocket for care. You can find providers in the UVA Provider Network on UVA's custom provider search at www.aetna.com/docfind/custom/uva/.

In-network providers are doctors, hospitals, and other healthcare providers that belong to Aetna's network. In-network providers represent a wide range of services, including:

- Primary care (general and family practitioners, pediatricians, internists and Ob/Gyns);
- Specialty care (such as, surgeons, cardiologists and urologists); and
- Health care facilities (such as hospitals, skilled nursing facilities and diagnostic testing labs).

In-network providers agree to provide services or supplies at negotiated charges. If you use an in-network provider, you'll pay less out of your own pocket for your care. You also won't have to fill out claim forms because your in-network provider will file claims for you.

To find an in-network provider in your area:

- Use Provider Search at www.aetna.com/docfind/custom/uva. Follow the prompts to search the online directory for a specific doctor, type of doctor, or all the doctors in a given zip code and/or travel distance.
- Call Member Services. Member Services representatives can help you find an in-network provider in your area. The Member Services' toll-free number is printed on your ID card.

You are not required to choose a primary care physician (PCP). However, regular preventive care is key to achieving good health, and your primary care physician can be your personal healthcare manager. He or she gets to know you and your special needs and problems and can recommend the right specialist when you need care that he or she can't provide.

About Your Cost for Care

If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred that are above the recognized charge.

Amounts above the recognized charge do not count toward your annual deductible or your out-of-pocket maximum.

Precertification

When You Need to Precertify Care

You are responsible for getting precertification for the services in the following chart if your care will be given by an out-of-network provider. The list may change from time to time. Contact Aetna Member Services to request the most current list.

Type of Service	When You Need to Precertify Out-of-Network Care
<p>Hospital Inpatient Care You must request precertification for inpatient confinement in a hospital</p>	<p>To request precertification, call Aetna Member Services at 800-987-9072 as follows:</p> <ul style="list-style-type: none"> ▪ Emergency admission: within 48 hours of admission or as soon as reasonably possible ▪ Urgent admission: before you are scheduled to be admitted ▪ Other admissions: at least 14 calendar days prior to admission
<p>Alternatives to Hospital Inpatient Care You must request precertification for the following hospital alternatives:</p> <ul style="list-style-type: none"> ▪ Skilled nursing facility care ▪ Home healthcare services ▪ Hospice care — inpatient and outpatient ▪ Residential treatment for treatment of mental disorders and substance abuse 	<p>To request precertification, call Aetna Member Services at 800-987-9072 as follows:</p> <ul style="list-style-type: none"> ▪ Inpatient confinements: same as hospital inpatient care (above) ▪ Outpatient care: <ul style="list-style-type: none"> - Non-emergency care — at least 14 calendar days in advance or as soon as reasonably possible - Emergency care — as soon as reasonably possible
<p>Outpatient Care You must request precertification for the following outpatient services:</p> <ul style="list-style-type: none"> ▪ Cosmetic and reconstructive surgery ▪ Gene-based, cellular and other innovative therapies (GCIT) 	<p>To request precertification, call Aetna Member Services at 800-987-9072 as follows:</p> <ul style="list-style-type: none"> ▪ Outpatient care: <ul style="list-style-type: none"> - Non-emergency care — at least 14 calendar days in advance or as soon as reasonably possible - Emergency care — as soon as reasonably possible

Aetna will notify you, your physician, and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days must be certified. You, your physician, or the facility will need to call Aetna at the number on your ID card no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a copy of this letter.

If You Don't Precertify

If you don't call when required, the medical plan will deny coverage for your expenses.

If precertification is:	Then charges are:
<i>requested and approved</i>	covered
<i>requested and denied</i>	not covered
<i>not requested, and the care is necessary</i>	charges are pended for review
<i>not requested, and the care is not necessary</i>	not covered

High-tech Radiology Precertification

Your doctor's office must submit a prior authorization request to Aetna for high-tech radiology services including MRI/MRA, CT/PCTA, PET, nuclear cardiology, diagnostic cardiology, facility-based sleep studies, cardiac implantable devices, hip/knee replacements, and pain management.

Your doctor's precertification requests will be reviewed. In a small number of cases, a request may be denied and an alternate recommendation may be made. Your physician may accept the alternate recommendation or submit an appeal.

Before Using an Out-of-Network Provider

If you use an out-of-network provider, you should ask if any required precertification has been submitted and confirmed. It is possible that your provider may bill you for procedures if he/she does not comply with the precertification process.

In an Emergency

No matter what medical option you are enrolled in, you have coverage 24 hours a day, 7 days a week, anywhere in the world, if care is needed to treat an emergency condition. If your emergency treatment results in an out-of-network hospital emergency admission, you must request precertification within 48 hours of admission or as soon as reasonably possible. (Please note, you may be transferred to an in-network facility once stabilized.)

An emergency medical condition is a recent and severe condition, sickness or injury, including (but not limited to) severe pain that would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health to believe that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy;
- Serious impairment to a bodily function(s);
- Serious dysfunction to a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the unborn child.

Examples of Medical Emergencies

- Heart attack or suspected heart attack;
- Poisoning or suspected poisoning;
- Severe shortness of breath;
- Uncontrolled or severe bleeding;
- Loss of consciousness;
- Suspected overdose of medication;
- Severe burns; or
- High fever (especially in infants).

Advanced Illness Resources

The Aetna Compassionate Care program offers service and support when you are facing difficult decisions about an advanced illness. The program's nurse case managers work with doctors to:

- Arrange for care and manage benefits;
- Find resources for the patient and family members; and
- Help family members and other caregivers manage the patient's pain and symptoms.

Call Aetna Member Services to talk with a nurse case manager about the Aetna Compassionate Care program. Online support is also available at www.aetnacompassionatecare.com.

Transplant and Special Medical Care

The National Medical Excellence Program (NME) can help you get care and helpful resources when you need it most — with one-on-one support through all phases of treatment. The program includes:

- National Transplant Program — coordinates care and provides access to covered treatment through the Institutes of Excellence™ Transplant Network.
- National Special Case Program — assists members with rare or complex conditions requiring specialized treatment to evaluate treatment options and obtain appropriate care.
- Out-of-Country Care Program — supports members who need emergency inpatient medical care while temporarily traveling outside the United States.

These services must be preauthorized by Aetna.

The Plan will pay for travel and lodging expenses beginning on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest of the following dates:

- One year after the day a covered procedure was performed; or
- On the date you cease to receive any services from the program provider in connection with the covered procedure; or
- On the date, your coverage terminates under the Plan.

Know What Is Covered

The Plan covers only those services, supplies and treatments considered necessary for your medical condition. The Plan does not cover treatment considered experimental or investigational (as determined by Aetna).

Travel and lodging expenses must be approved in advance by Aetna. The Plan does not cover expenses that are not approved.

Special Programs

You may take advantage of the value-added discount and health management programs described in this section

Discount Programs

You are eligible for discounts on health and wellness services and supplies. To learn more about these discounts, visit your secure member website at www.aetna.com.

To learn more about....	Visit your secure member website at www.aetna.com to read about....
<i>Fitness services</i>	Aetna Fitness discount program
<i>Hearing services and supplies</i>	Aetna Hearing discount program
<i>Savings on natural therapies and products</i>	Aetna Natural Products and Services Program
<i>Vision services and supplies</i>	Aetna Vision discount program
<i>Weight loss products and programs</i>	Aetna Weight Management discount program

Health Management Programs

Hoo’s Well

Hoo’s Well is the UVA Employee Wellness Program. It provides a number of programs and resources to help you create and maintain a healthy lifestyle. You may request a reasonable accommodation or alternative standard for health-related activities that offer an incentive. Visit www.hooswell.com for details.

Pregnancy Support

The Aetna Maternity Program helps you stay well throughout your pregnancy and after your baby is born. It provides:

- Information on prenatal care, labor and delivery, newborn care and more;
- A pregnancy risk survey to find out if you have any health conditions or risk factors that could affect your pregnancy;
- Extra support from obstetrically trained nurse case managers if you’re at risk during pregnancy and after delivery; and
- Smoke-Free Moms-to-Be, a nicotine-free smoking cessation program designed specifically for pregnant women.

How Do I Get Information About This Program?

As soon as Aetna is notified of your pregnancy, Aetna will reach out to you to get things started. Or you can call and enroll yourself at: **800-CRADLE-1 (800-272-3531)**.

When you participate in this program, all your care is coordinated by your Ob/Gyn and Aetna case managers.

Tools**Online Medical Provider Directory**

Provider Search is Aetna's online provider directory. Provider Search gives you the most recent information on the doctors, hospitals and other providers in the Aetna network. You can also find Aetna Benefits Information such as the "New Enrollee Information Package" and "Helping You Have a Healthy Pregnancy" on the Plan's custom Provider Search.

To access Provider Search, go to www.aetna.com/docfind/custom/uva and follow the prompts.

Aetna Member Website

Use your secure member website at www.aetna.com as your online resource for personalized benefit and health information. You can complete a variety of self-service transactions online. Once registered, you'll have access to:

- Print eligibility information;
- View ID card;
- Download copies of claim forms;
- Check the status of a claim;
- Find benefit balances;
- Contact Aetna Member Services; and
- Access health and wellness information.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Assistive Technology

Persons using assistive technology may not be able to fully access information on the member website. For assistance, please call 1-888-982-3862.

Language Assistance

TTY: 711

For language assistance in English call 1-888-982-3862 at no cost. (English)

Informed Health® Line

Get the help and information you need to make good healthcare decisions — 24 hours a day, 7 days a week — through Aetna’s Informed Health Line.

Informed Health’s tools and resources can help you make more informed decisions about your care, communicate better with your doctors, and save time and money, by showing you how to get the right care at the right time.

Call the Informed Health Line at **800-556-1555** to speak directly to a registered nurse about a wide variety of health and wellness topics.

Use the online Healthwise Knowledgebase to find out more about a health condition you have or medications you take in easy to understand terms. This online resource is available through your secure member website, at www.aetna.com.

ID Cards

You are encouraged to carry your ID cards with you at all times. Present the Aetna card to medical providers before receiving medical and behavioral health services. Present the OptumRx card to network pharmacies when purchasing prescription drugs. If your cards are lost or stolen, please notify the appropriate administrator immediately. An electronic copy of your ID card is available on Aetna’s member website at www.aetna.com or on Aetna’s app.

Coordination with Other Plans

If You Have Other Coverage

If you have coverage under other group or individual plans or receive payments for an illness or injury caused by another person, the benefits you receive from this Plan may be adjusted. This may reduce the benefits you receive from this Plan. The adjustment is known as coordination of benefits (COB).

Benefits available through other group or individual plans, contracts, or other arrangement including automobile insurance coverage where a health benefit is to be provided, arranged, or paid for on an insured or uninsured basis, are coordinated with this Plan.

Members involved in an automobile accident should contact Aetna regarding COB. “Other plans” include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, regardless of whether that plan is insured. This includes prepayment groups.
- Motor vehicle personal injury protection benefit (PIP) or optional motor vehicle insurance, to the extent of applicable law. Whenever legally possible, this Plan will be secondary.

To find out if benefits under this Plan will be reduced, Aetna must first use the rules listed below, in the order shown, to determine which plan is primary (pays its benefits first). The first rule that applies in the chart below will determine which plan pays first:

	If...	Then...
1.	<i>One plan as a COB provision and the other plan does not</i>	The plan without a COB provision determines its benefits and pays first.
2.	<i>One plan covers you as a dependent and the other covers you as an employee or retiree</i>	The plan that covers you as an employee or retiree determines its benefits and pays first. Note: If you are Medicare-eligible, this rule may be reversed. Please see rule 3 below.
3.	<i>You are eligible for Medicare and not actively working</i>	These Medicare Secondary Payer rules apply: <ul style="list-style-type: none"> ▪ The plan that covers you as a dependent of a working spouse determines its benefits and pays first. ▪ Medicare pays second. ▪ The plan that covers you as a retired employee pays third.
4.	<i>A child's parents are married or living together (whether or not married)</i>	The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.
5.	<i>A child's parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child's health expenses to either parent, or states that both parents are responsible for the child's health coverage</i>	The "birthday rule" described in rule 4 above applies.
6.	<i>A child's parents are separated or divorced, and a court decree assigns responsibility for the child's health expenses to one parent</i>	The plan covering the child as the assigned parent's dependent determines its benefits and pays first.
7.	<i>A child's parents are separated, divorced, or not living together (whether or not they have ever been married) and there is no court decree assigning responsibilities for the child's health expenses to either parent</i>	Benefits are determined and paid in this order: <ul style="list-style-type: none"> ▪ The plan of the custodial parent pays, then ▪ The plan of the spouse of the custodial parent pays, then ▪ The plan of the non-custodial parent pays, then ▪ The plan of the spouse of the non-custodial parent pays.

If...	Then...
<p>8. <i>You have coverage as an active employee (that is, not as a retiree or laid off employee) and coverage as a retired or laid off employee. Or you have coverage as the dependent of an active employee and coverage as the dependent of a retired or laid off employee</i></p>	<ul style="list-style-type: none"> ▪ The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first. ▪ This rule is ignored if the other plan does not contain the same rule. <p>Note: this rule does not apply if the rule 2 (above) has already determined the order of payment.</p>
<p>9. <i>You are covered under a federal or state right of continuation law (such as COBRA)</i></p>	<p>The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first.</p> <p>This rule is ignored if the other plan does not contain the same rule.</p> <p>Note: this rule does not apply if rule 2 (above) has already determined the order of payment.</p>
<p>10. <i>The above rules do not establish an order of payment</i></p>	<p>The plan that has covered you for the longest time will determine its benefits and pay first.</p>

When the other plan pays first, the benefits paid under this Plan are reduced as shown here:

- The amount this Plan would pay if it were the only coverage in place, minus
- Benefits paid by the other plan(s).

This prevents the sum of your benefits from being more than you would receive from just this Plan.

If your other plan(s) pays benefits in the form of services rather than cash payments, the Plan uses the cash value of those services in the calculation.

Coordination with Medicare

You are eligible for Medicare if you are:

- Eligible for, and covered by, Medicare;
- Eligible for, but not covered by, Medicare because you:
 - Refused Medicare coverage;
 - Dropped Medicare coverage; or
 - Did not make a proper request for Medicare coverage.

When you are eligible for Medicare, Aetna must determine whether this Plan or Medicare is the primary plan.

When This Plan Is Primary

This Plan is primary and Medicare is secondary if a covered person is eligible for Medicare and falls into one of the following categories unless eligible for Medicare due to End Stage Renal Disease (ESRD):

- An active employee, regardless of age;
- A totally disabled employee who is:
 - Not terminated or retired; or
 - Not receiving Social Security retirement or Social Security disability benefits.
- A Medicare-eligible dependent spouse of:
 - An active employee; or
 - A totally disabled employee who is not terminated or retired.
- Any other person for whom this Plan's benefits are payable to comply with federal law.

When this Plan is the primary plan, Aetna will not take Medicare benefits into consideration when determining the benefits payable by the Plan.

End-Stage Renal Disease

This Plan is primary for the first 30 months after any covered person becomes eligible for Medicare due to End Stage Renal Disease (ESRD). The Plan will pay benefits for a covered expense first before Medicare benefits are available.

Medicare becomes the primary plan and this Plan is secondary beginning with the 31st month of Medicare eligibility due to ESRD. If you're eligible for Medicare only because of permanent kidney failure, your Medicare coverage will end 12 months after the month in which you stop dialysis treatments or 36 months after the month in which you have a kidney transplant.

When Medicare Is Primary

Medicare is the primary plan and this Plan is secondary if a covered person is eligible for Medicare and does not fall into one of the categories above or is in their 31st month or later of Medicare eligibility due to ESRD.

These rules are based on regulations issued by the Centers for Medicare and Medicaid Services (CMS), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer Rules. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay Benefits in accordance with CMS regulations.

When Eligibility for the Plan Ends

Medicare is the primary plan, and enrollment in this Plan will end if a covered person is eligible for Medicare and is:

- A retired employee;
- A totally disabled employee who is terminated or retired;
- A Medicare-eligible dependent of:
 - A retired employee; or
 - A totally disabled employee who is terminated or retired.

How Medicare Affects Your Plan Benefits

When Medicare is your primary plan as described above, this Plan is secondary and pays benefits based on:

- If the provider accepts Medicare assignment, benefits are based on Medicare's approved amount for the service you've received; or
- If the provider doesn't accept Medicare assignment, benefits are based on Medicare's balance billing limit.

The Plan's benefit for a covered service is figured by:

- Calculating the allowable expense, depending on whether the provider accepts or does not accept Medicare assignment (see above); then
- Applying the Plan's deductible and coinsurance to the allowable expense; then
- Subtracting the amount payable by Medicare (even if you haven't signed up for Medicare and therefore haven't received Medicare reimbursement).

Keep in Mind

Once you are eligible for Medicare and it is your primary plan as described above, the Plan's benefits are calculated as though you have enrolled in Part B — whether or not you have actually enrolled. This is why it's important to be enrolled in Part B when Medicare becomes your primary plan.

What Is Covered

In this section, you will find more detailed information about the services and supplies covered by the Plan. It's important to remember that the Plan covers only services and supplies that are necessary to diagnose or treat a non-occupational illness or injury. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this book.

This section and "[What Is Not Covered](#)" on page 83 should be read together to learn more about what is covered and not covered under the Plan for certain conditions, procedures, services, and supplies.

Preventive Care

These preventive care services are covered.

Routine Physical Exams

The Plan covers charges for a routine physical exam. Included as part of the exam are:

- X-rays, laboratory services, and other tests that are routinely preventive in accordance with the recommendations of the United States Preventive Services Task Force, and coded as such given in connection with the exam; and
- Immunizations for infectious diseases in accordance with the recommendations of the Centers for Disease Control and Prevention, and the materials needed to administer the immunizations.
- Testing for tuberculosis.

The exam must be given by a physician or under the direction of a physician.

If an exam is given to diagnose or treat a suspected or identified injury or disease, it is *not* considered a routine physical exam. Contact Aetna Member Services at 1.800.987.9072 with questions regarding covered charges for a routine physical exam.

Keep in Mind

The Plan does not pay benefits for school or employment-related exams, or for those needed to take part in school athletic programs.

Screening and Counseling Services

The Plan covers charges made by your physician for the following in an individual or group setting:

- Obesity: screening and counseling services to help you lose weight if you are obese. Coverage includes:
 - Preventive counseling visits;
 - Nutritional counseling; and
 - Healthy diet counseling visits for those with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease.
- Use of tobacco products: screening and counseling services to help you stop using tobacco products. A tobacco product is a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco. Coverage includes:
 - Preventive counseling visits;
 - Treatment visits; and
 - Class visits.
- Misuse of alcohol and/or drugs: screening and counseling services to help prevent or reduce the use of alcohol or controlled substances. Coverage includes:
 - Preventive counseling visits;
 - Risk factor reduction intervention; and
 - A structured assessment.

Preventive care coverage also includes the following services for women:

- Screening and counseling services for:
 - Interpersonal and domestic violence;
 - Sexually transmitted diseases (up to two occurrences per year);
 - Human Immune Deficiency Virus (HIV);
 - High risk Human Papillomavirus (HPV); and
 - Genetic risk counseling for breast and ovarian cancer.
- Screening for gestational diabetes.
- Screening for urinary incontinence.

Benefits for screening and counseling services are subject to visit maximums which are available from Aetna Member Services at the number on your ID card.

Routine Ob/Gyn Exams

The Plan covers routine Ob/Gyn exams, including Pap smear and related laboratory fees.

Routine Cancer Screenings

The Plan covers:

- Mammograms; and
- Digital rectal exam (DRE) and prostate specific antigen (PSA) tests for men; and
- Colorectal screening including fecal occult blood test, sigmoidoscopy, colonoscopy and double contrast barium enema; and
- Lung cancer screening; and
- Skin cancer screening.

Keep in Mind

The Plan covers mammograms and colorectal screenings at 100% with no deductible when in-network providers are used, regardless of diagnosis.

Visits and Walk-In Clinics

Office Visits

The Plan covers treatment by a doctor or nurse practitioner or physician assistant in his or her office.

Coverage includes:

- Allergy testing and treatment;
- Immunizations for infectious disease; and
- Supplies, radiology services, X-rays and tests given by the physician.

Keep in Mind

The Plan does not cover immunizations that are needed only for travel or employment.

Home Visits

The Plan covers treatment by a doctor in your home.

Walk-In Clinics

A walk-in clinic is a free-standing healthcare facility. The Plan covers visits to these walk-in clinics for non-emergency treatment of an illness or injury, and for administration of certain immunizations at the same benefit level as office visits.

Keep in Mind

Walk-in clinics are not an alternative to emergency room services, and they do not provide ongoing physician care.

Telemedicine

The Plan covers telemedicine services for any professional clinical service, including critical care and inpatient consultations, provided over a distance via a secure telecommunications system. Telemedicine services require, at a minimum:

- Audio and video equipment permitting two-way, real-time interactive communication between the patient and a distant site physician or practitioner for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of healthcare services.
- Authorized originating site can include offices of physicians or practitioners, hospitals, dialysis center, rural health clinic, or skilled nursing facility; distant site practitioner can include physicians, nurse practitioners, physician assistants, or clinical social workers.
- The same deductible and cost sharing amount that is used to process the service without the telehealth modifier applies.

Teladoc

The Plan covers access to board certified doctors by phone, video, or mobile app using Teladoc Health and the Teladoc network of providers.

- **General Medicine:** 24/7 on-demand access to U.S board-certified doctors for non-emergency needs such as cold, flu, bronchitis, sinusitis, sore throat, infection, rash, pink eyes, upper respiratory illness, strains, and sprains. Teladoc physicians can diagnose and prescribe medication, if necessary.
- **Behavioral Health Care Service:** Secure confidential ongoing support for anxiety, stress, and depression. Board-certified psychiatrists, psychologists, and licensed therapists are available seven days a week, 7am to 9pm.
- **Dermatology:** Upload images and provide details about your skin issue to receive a response in two business days from a licensed dermatologist. Seven-day follow-up included.
- **Caregiving:** Extend Teladoc general medicine services to someone for whom you provide care with a two-way or three-way video or phone visit with a licensed doctor.

Go to <https://member.teladoc.com/aetna> to set up your Teladoc account and request a visit.

Family Planning and Maternity

Contraception Services

The Plan covers the following contraceptive services and supplies when obtained from, and billed by, your physician:

- Contraceptive counseling.
- Contraceptive devices prescribed by a physician.
- Office visit for the injection of injectable contraceptives.
- Related outpatient services such as consultations, exams, and procedures.

Other contraceptives may be covered as part of the prescription drug program administered by OptumRx. Refer to the Prescription Drug Program section for more information.

Voluntary Sterilization

The Plan covers charges made by a physician or hospital for a vasectomy or tubal ligation. The Plan does not cover the reversal of a sterilization procedure.

Basic Infertility Services

Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be eligible for comprehensive infertility and ART benefits, you must be covered under this *Summary Plan Description* as an employee or as a covered dependent who is the employee's legal spouse.

Even though not incurred for treatment of an illness or injury, covered expenses include those incurred by an eligible covered female for infertility if all of the following tests are met:

- A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist or an infertility specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than 19 miU on day 3 of the menstrual cycle.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under the Plan.

Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon preauthorization by Aetna, subject to all the Plan's exclusions and limitations:

- Ovulation induction with menotropins is subject to the maximum benefit shown in "[Your UVA Medical Coverage Options](#)" on page 28 and has a maximum of 6 cycles per lifetime where lifetime is defined to include services received or provided by the UVA Health Plan; and
- Intrauterine insemination is subject to the maximum benefit shown in "[Your UVA Medical Coverage Options](#)" on page 28 and has a maximum of 6 cycles per lifetime where lifetime is defined to include services received or provided by the UVA Health Plan.

Advanced Reproductive Technology (ART) Benefits

ART services include:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.

Eligibility for ART Benefits

To be eligible for ART benefits under the Health Plan, you must meet the requirements above and:

- First, exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your physician to Aetna's infertility case management unit;
- Obtain pre-authorization from Aetna's infertility case management unit for ART services by an ART specialist.

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Plan's exclusions and limitations

- Up to 3 cycles and subject to the maximum benefit shown in the Schedule of Benefits section of any combination of the following ART services per lifetime (where lifetime is defined to include all comprehensive infertility services and ART services received or provided by the UVA Health Plan) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the Schedule of Benefits section while covered under the UVA Health Plan;
- Payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART when the spouse is also covered under the UVA Health Plan.

Pre-authorization Required

Treatment of infertility must be pre-authorized by Aetna. Treatment received without pre- authorization will not be covered. You will be responsible for full payment of the services.

Refer to the Schedule of Benefits for details about the maximums that apply to infertility services. The lifetime maximums that apply to infertility services apply differently than other lifetime maximums under the Plan.

Maternity Care

The Plan covers prenatal, delivery and postnatal maternity care. In accordance with the Newborns' and Mothers' Health Protection Act, the Plan covers inpatient care of the mother and newborn child for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

If you and your attending physician agree to an earlier discharge from the hospital, the Plan will pay for one post-delivery home visit by a healthcare provider.

Precertification is not required for the first 48 hours of hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits must be precertified. You, your doctor, or another healthcare provider can request precertification by calling the number on your ID card.

About Home Births

The Plan does not cover home births. This is childbirth that takes place outside a hospital or birthing center, or in a place that is not licensed to perform deliveries.

Birthing Center

The Plan covers prenatal, delivery, and postnatal maternity care provided by a birthing center. Postnatal care must be given within 48 hours after a vaginal delivery, or 96 hours after a cesarean section.

Breastfeeding Support, Counseling and Supplies

The Plan covers:

- Breastfeeding assistance, training and counseling services by a certified lactation support provider in a group or individual setting.
- Purchase of a standard (not hospital-grade) electric breast pump if you have not purchased either a standard electric or manual pump within the past three years. The pump must be purchased within 60 days from the date of the birth.
- Purchase of a manual breast pump if you have not purchased either a standard electric or manual pump within the past three years. The pump must be purchased within 12 months from the date of the birth.
- Purchase of the accessories needed to operate the breast pump.

If you use a breast pump from a prior pregnancy, the Plan covers the purchase of a new set of breast pump supplies within the first 12 months following the birth.

Hospital Care

The Plan covers charges made by a hospital for room and board when you are confined as an inpatient. Room and board charges are covered up to the hospital's semi-private room rate.

The Plan also covers other services and supplies provided during your inpatient stay, such as:

- Ambulance services when the service is owned by the hospital;
- Physician and surgeon services when they are employed by the hospital;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products, but not the cost of the blood or blood product;
- Radiation therapy;
- Physical, occupational and speech therapy;
- Oxygen and oxygen therapy;

- X-rays, laboratory tests and diagnostic services;
- Medications
- Intravenous (IV) preparations; and
- Discharge planning.

About Hospital Charges

The Plan does not cover private room charges that exceed the hospital's semi-private room rate unless a private room is medically necessary because of a contagious illness or immune system problems.

If a hospital does not itemize room and board charges, as well as other charges, Aetna will assume that 40 percent of the total is for room and board and 60 percent is for other charges.

Some physicians and other providers may bill you separately for services given during your hospital stay. If you receive services from a radiologist, anesthesiologist, or pathologist who is not in the Aetna network (an out-of-network provider) during an inpatient stay at an in-network facility, the Plan will cover those services at the in-network benefit level.

Pre-Admission Testing

The Plan covers outpatient testing done by a hospital, surgery center, physician, or licensed diagnostic lab before a covered surgical procedure. The tests must be:

- Related to surgery that will take place in a hospital or surgery center;
- Completed within 14 days of your surgery;
- Performed on an outpatient basis;
- Covered if you were confined in a hospital; and
- Included in your medical record kept by the hospital or surgery center where the surgery takes place.

The tests are covered only if they are not repeated in or by the hospital or surgery center where the surgery will take place.

About Surgery Coverage

If your tests indicate that surgery should not be performed because of your physical condition, the Plan covers the tests but not the proposed surgery.

Surgery

The Plan covers the charges made by a physician for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another physician to obtain a second opinion prior to the surgery.

About Surgery Coverage

You may need to have multiple surgical procedures done at the same time or during a single operating session. The Plan normally pays a lower percentage of the fees that are charged for the secondary procedure(s).

The Plan does not cover any surgery that is not medically necessary, even if performed with another procedure that is necessary.

Pre-operative and post-operative visits by your surgeon are considered to be part of the surgical fee. The Plan does not cover separate fees for pre-operative and post-operative care.

Surgery performed by a physician who is not in the Aetna network will be covered as out-of-network care and subject to recognized charge limits even if the surgery is performed in an in-network hospital, unless the surgery is an emergency.

Anesthesia

The Plan covers the administration of anesthetics and oxygen by a physician (other than the operating physician) or Certified Registered Nurse Anesthetist (CRNA) in connection with a covered procedure.

Bariatric Surgery

The Plan covers inpatient or outpatient charges made by a hospital or a physician for the medically necessary surgical treatment of morbid obesity. Bariatric surgery must be approved in advance by Aetna.

Coverage includes one morbid obesity surgical procedure, including related outpatient services, within a two-year period that starts with the date of the first surgical procedure to treat morbid obesity, unless a multistage procedure is planned.

Bariatric procedures must be performed in a Bariatric Institute of Quality (IOQ). There is no out-of-network coverage. If no IOQ facility is available within 100 miles of your residence, travel and lodging for you and one companion is reimbursed if IOQ services, travel and lodging is pre-approved. Call Aetna Member Services to answer your questions and to help you find an in-network provider.

Keep in Mind

The Plan does not cover bariatric surgery when done for cosmetic reasons.

Refer to Aetna's Clinical Policy Bulletins (CPB) to learn more about coverage for weight loss surgery. You can find the CPBs at www.aetna.com.

Oral Surgery

The Plan covers treatment of accidental injury to natural teeth and oral surgery that is considered medical-in-nature, including treatment for:

- Disease of the facial bones;
- Trauma to the soft and hard tissue structures of the face and oral cavity; and
- Correcting facial deformities present at birth or later may be covered with prior review and approval for medical necessity. Services solely for cosmetic purposes are not covered.

Surgery that is dental-in-nature involves the teeth and is not covered by the UVA Health Plan. Only oral surgery that is medical-in-nature is covered by the UVA Health Plan. Tooth surgery is covered by the UVA Dental Plan.

The Plan covers:

- Hospital services and supplies received for an inpatient hospital confinement that is required because of your condition are covered.
- Services of a physician or dentist for treatment of the following conditions of the teeth, mouth, jaws, jaw joints, or supporting tissues if medically necessary:
 - Surgery necessary to treat a fracture, dislocation or wound;
 - Surgery necessary to alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot improve function;
 - Surgery necessary to cut out cysts, tumors, or other diseased tissues;
 - Surgery to cut into gums and tissues of the mouth, as long as this is not done in connection with the removal, replacement, or repair of teeth; and
 - Non-surgical treatment of infections or diseases not related to the teeth.
- Treatment of accidental injury to sound natural teeth or tissues of the mouth. The treatment must occur within 24 months of the accident. The teeth must have been free from decay or in good repair, and firmly attached to the jawbone at the time of the injury.
- The Plan's coverage of dentures, bridgework, crowns, and appliances is limited to:
 - The first denture or fixed bridgework to replace lost teeth;
 - The first crown (cap) needed to repair each damaged tooth; and
 - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Outpatient Surgery

The Plan covers outpatient surgery in:

- The office-based surgical facility of a physician or dentist;
- A surgery center; or
- The outpatient department of a hospital.

The surgery is covered only if it:

- Can be performed adequately and safely only in a surgery center or hospital; and
- Is not normally performed in a physician's or dentist's office.

The Plan covers the following outpatient surgery expenses:

- Services and supplies provided by the hospital, surgery center, or office-based surgical facility on the day of the procedure;

- The operating physician's services for performing the procedure, related pre- and post-operative care, and the administration of anesthesia; and
- Services of another physician for related post-operative care and the administration of anesthesia (other than a local anesthetic).

The Plan does *not* cover the services of a physician who renders technical assistance to the operating physician.

Reconstructive Surgery

The Plan covers reconstructive and cosmetic surgery if the surgery is needed:

- To repair an accidental injury that happens while you are covered by the Plan.
- To correct a severe anatomical defect present at birth (or appearing after birth) if:
 - The defect has caused severe facial disfigurement or significant functional impairment; and
 - The purpose of the surgery is to improve function.
- To improve function when the treatment of an illness has resulted in severe facial disfigurement or significant functional impairment of a body part.
- To implant or attach a covered prosthetic device.
- As part of reconstruction following a mastectomy.

Transgender Reassignment (Sex Change) Surgery

Covered expenses include charges in connection with a medically necessary Transgender Reassignment (sometimes called Sex Change) Surgery as long you or a covered dependent have obtained precertification from Aetna.

Covered expenses include:

- Charges made by a physician for:
 - Performing the surgical procedure; and
 - Pre-operative and post-operative hospital and office visits.
- Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the hospital's semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.
- Charges made by a Skilled Nursing Facility for inpatient services and supplies. Daily room and board charges over the semi-private rate will not be covered.
- Charges made for the administration of anesthetics.
- Charges for outpatient diagnostic laboratory and x-rays.
- Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing, and storage of self-donated blood after the surgery has been scheduled.

Precertification Is Necessary for Coverage

No payment will be made for any covered expenses under this benefit unless they have been precertified by Aetna.

Transplants***If You Need a Transplant***

Call Aetna Member Services when you and your physician begin to discuss transplant services. Member Services can answer benefit questions, help you find an in-network provider, tell you about the services offered by the National Medical Excellence Program, and refer you to the Special Case Customer Service Unit to start the transplant authorization process.

In general, there are four phases in the transplant process:

- Pre-transplant evaluation and screening. This phase includes evaluation and acceptance into a transplant facility's transplant program.
- Pre-transplant candidacy screening. This phase includes compatibility testing of prospective organ donors who are immediate family members.
- Transplant event: This phase includes organ procurement, surgical procedures and medical therapies related to the transplant.
- Follow-up care. During this phase, you may need home healthcare services, home infusion services, and other outpatient care.

A transplant coverage period begins at the point of evaluation for a transplant and ends on the later of:

- 180 days from the date of the transplant; or
- The date you are discharged from a hospital or outpatient facility for the admission or visit(s) related to the transplant.

The Plan covers:

- Evaluation.
- Compatibility testing of prospective organ donors who are immediate family members.
- Charges for activating the donor search process with national registries.
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor's group or individual health plan.
- Physician or transplant team services for transplant expenses.
- Hospital inpatient and outpatient supplies and services, including:
 - Physical, speech and occupational therapy;
 - Biomedicals and immunosuppressants;
 - Home healthcare services; and
 - Home infusion services.
- Follow-up care.

Aetna offers a wide range of support services to those who need a transplant or other complex medical care. If you need a transplant, you or your physician should contact Aetna’s National Medical Excellence Program at **877-212-8811**. A nurse case manager will provide the support and help you and your physician need to make informed decisions about your care.

Refer to “[Transplant and Special Medical Care](#)” on page 52 for more information about the National Medical Excellence Program.

The Institutes of Excellence Network

Through the Institutes of Excellence (IOE) network, you have access to a provider network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants based on quality of care and successful clinical outcomes. Through the IOE Program, you can receive care for the following transplants:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-Cell receptor therapy for FDA approved treatments

The Plan options cover the transplant as in-network care only when it is performed at an IOE facility. Transplants performed at any non-IOE facility are *not* covered.

Alternatives to Hospital Inpatient Care

Skilled Nursing Facility

The Plan covers charges made by a skilled nursing facility during an inpatient stay, up to the maximum shown in the Schedule of Benefits, (see “[Your UVA Medical Coverage Options](#)” on page 28), including:

- Room and board charges, up to the semi-private room rate. The Plan covers up to the private room rate if it is appropriate because of an infectious illness or a weak or compromised immune system.
- General nursing services.
- Use of special treatment rooms.
- Physical, occupational, or speech therapy.
- Radiology services and lab work.
- Oxygen and other gas therapy.

Home Health Care

The Plan covers home healthcare services when ordered by a physician and given to you under a home healthcare plan while you are homebound. Coverage includes:

- Part-time nursing care that requires the medical training of, and is given by, an RN or by an LPN if an RN is not available. The services must be provided during intermittent visits of four hours or less.
- Part-time home health aide services when provided in conjunction with, and in direct support of, care by an RN or LPN. The services must be provided during intermittent visits of four hours or less.

- Medical social services by a qualified social worker when provided in conjunction with, and in direct support of, care by an RN or LPN.
- Medical supplies, prescription drugs, and lab services given by (or for) a home healthcare agency. Coverage is limited to what would have been covered if you had remained in a hospital.

Keep in Mind

Physical, speech, and occupational therapy given as part of a home health care plan are subject to the maximums shown in the Schedule of Benefits.

Hospice Care

The Plan covers hospice care for a person who is terminally ill. The Plan covers:

- Charges made by a hospice facility, hospital or skilled nursing facility for:
 - Room and board and other services and supplies provided for pain control and other acute and chronic symptom management. The Plan covers charges for room and board up to the facility's semi-private room rate.
 - Services and supplies provided on an outpatient basis.
- Charges made by a hospice care agency for:
 - Part-time or intermittent nursing care by an RN or LPN for up to eight hours in a day.
 - Part-time or intermittent home health aide services for up to eight hours in a day.
These services consist mainly of caring for the patient.
 - Medical social services under a physician's direction.
 - Psychological and dietary counseling.
 - Consultation or case management services provided by a physician.
 - Physical and occupational therapy.
 - Medical supplies.
- Charges made by providers who are not employed by the hospice care agency, as long as the agency retains responsibility for your care:
 - A physician for consultation or case management.
 - A physical or occupational therapist.
 - A home healthcare agency for:
 - Physical and occupational therapy.
 - Part-time or intermittent home health aide services for up to eight hours in any one day.
 - Medical supplies.
 - Psychological or dietary counseling.

The Aetna Compassionate Care Program offers support and services to those facing the advanced stages of an illness. Refer to "[Advanced Illness Resources](#)" on page 52 for more information.

Emergency and Urgent Care

Emergency Care

The Plan covers emergency care provided in a hospital emergency room or a free-standing emergency facility. The care must be for an emergency condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physician services;
- Hospital nursing staff services; and
- Radiology and pathology services.

ER Care Only for Emergencies

The Plan does not cover non-emergency care given in a hospital emergency room.

Urgent Care

The Plan covers the services of a hospital or urgent care provider to evaluate and treat an urgent condition. Urgent care providers are physician-staffed facilities offering unscheduled medical services and billing as an urgent care facility.

The urgent care benefits cover:

- Use of urgent care facilities;
- Physician services;
- Nursing staff services; and
- The services of radiologists and pathologists.

Urgent Care Only

The Plan does not cover non-urgent care given by urgent care providers.

Ambulance

The Plan covers charges made for a professional ambulance. The conditions for coverage vary with the type of vehicle used.

Ground Ambulance

The Plan covers:

- Transportation in a medical emergency to the first hospital where treatment is given;
- Transportation in a medical emergency from one hospital to another hospital when the first hospital does not have the required services or facilities for your condition;
- Transportation from hospital to home or to another facility when an ambulance is medically necessary for safe and adequate transport; and
- Transportation while confined in a hospital or skilled nursing facility to receive medically necessary inpatient or outpatient treatment when an ambulance is required for safe and adequate transport.

Air or Water Ambulance

The Plan covers transport to a hospital by air or water ambulance when:

- Ground ambulance is not available; and
- Your condition is unstable and requires medical supervision and rapid transport. In a medical emergency, transport by air or water ambulance from one hospital to another hospital is covered if:
 - The first hospital does not have the required services or facilities for your condition; and
 - Ground ambulance is not available; and
 - Your condition is unstable and requires medical supervision and rapid transport.

Other Covered Expenses

This section describes other covered expenses for both inpatient and outpatient care. The Plan's standard level of benefits applies to these expenses, unless shown otherwise.

Acupuncture

The Plan covers charges for acupuncture services provided by a licensed provider if the acupuncture services are:

- a form of anesthesia in connection with a covered surgical procedure;
- to alleviate chronic pain;
- to treat:
 - postoperative and chemotherapy-induced nausea and vomiting;
 - nausea of pregnancy;
 - postoperative dental pain;
 - temporomandibular disorders (TMD);
 - migraine headache; or
 - pain from osteoarthritis of the knee or hip (adjunctive therapy).

Autism Spectrum Disorder

Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavior Analysis) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist, or licensed clinical social worker as part of a Treatment Plan; and the covered child is diagnosed with Autism Spectrum Disorder.

Applied Behavior Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Chemotherapy

Coverage for chemotherapy depends on where you receive treatment:

- In most cases, chemotherapy is covered as outpatient care. The medication is sometimes a specialty drug and must be requested through the Prescription Drug Program and filled at the UVA Specialty Pharmacy. Contact OptumRx Member Service Department at 877-629-3123 for a list of specialty drugs;
- The Plan covers the initial dose of chemotherapy given in the hospital when:
 - You have been hospitalized for the diagnosis of cancer; and
 - A hospital stay is necessary based on your health status.

Diabetic Equipment, Supplies, and Education

The Plan covers the following services and supplies used in the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Foot care to minimize the risk of infection; and
- Self-management training provided by a licensed healthcare provider who is certified in diabetes self-management training.

Diagnostic X-Ray and Laboratory

The Plan covers necessary X-rays, laboratory services, and pathology tests to diagnose an illness or injury.

Use In-Network Providers to Minimize Your Costs

It's important to use in-network providers to keep your share of the cost as low as possible. Before going to an outpatient facility for diagnostic tests, make sure that the facility is in the network. Also, remind your provider to use in-network labs for services provided to you. Tests and lab work done by an out-of-network provider or facility will be covered as out-of-network care ***even if your tests were ordered by an in-network physician.***

Your provider may be responsible for precertifying high-tech radiology procedures. Refer to “[Precertification](#)” on page 50 for additional information.

Durable Medical and Surgical Equipment

The Plan covers the rental of durable medical and surgical equipment. Examples include wheelchairs, crutches, hospital beds, and oxygen for home use. The Plan covers only one item for the same (or a similar) purpose, plus the accessories needed to operate the item.

Instead of rental, the Plan may cover the purchase of equipment if:

- It either can't be rented or would cost less to purchase than to rent; and
- Long-term use is planned.

The Plan also covers the repair of this equipment when necessary. Maintenance and repairs needed because of misuse or abuse of the equipment are not covered.

Replacement is covered if you show Aetna that the replacement is needed because of a change in the person's physical condition or if it is likely to cost less to purchase a replacement than to repair existing equipment or rent similar equipment.

Early Intervention Services

For children from birth to 36 months of age, the Plan covers charges for routine and necessary immunizations administered on an outpatient basis. The Plan also covers charges for infant hearing screenings and necessary audiological exams for newborn children that are provided in accordance with the Virginia Hearing Impairment Identification and Monitoring System and include the use of approved technology. For infants whose hearing screenings indicated the need for a diagnostic audiological exam, coverage includes a follow-up audiological exam recommended by a physician or audiologist. The exam must be performed by a licensed audiologist.

The Plan offers special provisions for developmentally disabled children from birth to 36 months that qualify under the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. & 1471 et.al.). Medically necessary services that help an affected child attain or retain the ability to function age-appropriately are covered, such as speech and language therapy, occupational therapy, physical therapy, assistive technology services, and devices.

Benefits and limits to the early intervention services are determined by the Commonwealth of Virginia as stated in the Virginia Code.

Coverage for early intervention services are subject to the lifetime maximum shown in the Schedule of Benefits (see "[Your UVA Medical Coverage Options](#)" on page 28).

Experimental or Investigational Services

In general, the Plan does not cover drugs, devices, treatments, or procedures that are experimental or investigational. There are, however, some situations where the Plan will cover a drug, device, treatment, or procedure that would otherwise be considered experimental or investigational.

The Plan will cover care that is considered experimental or investigational if the care meets all the following conditions:

- You have been diagnosed with cancer or a condition likely to cause death within one year;
- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria:
 - The drug, device, treatment, or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
 - The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation;

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the U.S. Food and Drug Administration or the Department of Defense) and conforms to NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

Gene-based, cellular and other innovative therapies (GCIT)

GCIT are any services that are gene-based, cellular and innovative therapeutics. They have a basis in genetic/molecular medicine. Covered services include GCIT provided by a physician, hospital, or other provider. The Plan covers the following services for GCIT:

- Cellular immunotherapies;
- Genetically modified oncolytic viral therapy;
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions;
- All human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
 - Luxturna® (Voretigene neparvovec);
 - Zolgensma® (Onasemnogene abeparvovec-xioi); and
 - Spinraza® (Nusinersen);
- Products derived from gene editing technologies, including CRISPR-Cas9; and
- Oligonucleotide-based therapies. Examples include:
 - Antisense (an example is Spinraza);
 - siRNA;
 - mRNA; and
 - microRNA therapies.

The Plan covers the following services ***only if you have received prior written approval from Aetna:***

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider; or
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Aetna designates physicians, hospitals, and other providers as GCIT-designated facilities/providers to provide gene-based, cellular, and other innovative therapies.

GCIT-designated Facilities/Providers

You must receive GCIT covered services from GCIT-designated facilities/providers. If there are no GCIT-designated facilities/providers assigned in your local network, Aetna will arrange for and coordinate your care at a GCIT-designated facility/provider. If you do not receive your GCIT services at the facility/provider designated by Aetna, they will not be covered.

Infusion Therapy

Infusion therapy is the intravenous or continuous administration of medications or solutions as part of your treatment. The Plan covers infusion therapy given on an outpatient basis by:

- A free-standing clinic;
- The outpatient department of a hospital; or
- A physician in his/her office or in your home.

Coverage includes the following services and supplies:

- The pharmaceutical administered. In some cases, the pharmaceutical is a specialty drug and must be requested through the Prescription Drug Program and filled at the UVA Specialty Pharmacy. Contact OptumRx Member Service Department at 1-877-629-3123 for a list of specialty drugs;
- Any medical supplies, equipment, and nursing services needed to support the therapy;
- Total parenteral nutrition;
- Chemotherapy;
- Drug therapy, including antibiotics and antivirals;
- Pain management; and
- Hydration therapy, including fluids, electrolytes, and other additives.

Nutritional Counseling

The Plan covers medically necessary nutritional counseling services performed by a licensed or certified nutritionist or dietician.

Outpatient Complex Imaging

The Plan covers complex imaging services to diagnose an illness or injury, including:

- Computerized axial tomography (CAT) scans;
- Magnetic Resonance Imaging (MRI); and
- Positron Emission Tomography (PET) scans.

Your provider may be responsible for precertifying high-tech radiology procedures. Refer to the Precertification section for additional information.

Outpatient Radiology Services

The Plan covers radiology services provided by a physician, hospital, or licensed radiology facility or lab to diagnose an illness or injury.

Outpatient Short-Term Rehabilitation

Physical, Occupational and Speech Therapy

The Plan covers short-term, outpatient rehabilitation therapy to improve a body function lost as the result of an illness or injury. The treatment must be:

- Part of a treatment plan;
- Provided by a physician or a licensed or certified physical, occupational or speech therapist;
- Expected to result in significant improvement of the condition within 60 days of the start of treatment.

Covered expenses include services for:

- Physical therapy expected to significantly improve, develop or restore physical functions that were lost or impaired because of an acute illness, injury, or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy expected to:
 - Significantly improve, develop, or restore physical functions lost or impaired because of an acute illness, injury, or surgical procedure, or
 - Re-teach skills to improve independence in the activities of daily living.

Occupational therapy does not include educational training or services designed to develop physical function.

- Speech therapy:
 - To restore the loss of speech function or correct a speech impairment resulting from disease or injury; or
 - To treat delays in the development of speech function that are the result of a gross anatomical defect present at birth (for example: a cleft palate or a cleft lip).

The Plan limits benefits for physical and occupational therapy and for speech therapy. Maximums are shown in the Schedule of Benefits (see “[Your UVA Medical Coverage Options](#)” on page 28).

Habilitation Therapy Services for Children Through Age 4

The Plan covers outpatient habilitation therapy to help you keep, learn, or improve skills and functioning for daily living. The treatment must be:

- Part of a specific treatment plan ordered by a physician;
- Provided by a physician, a licensed or certified occupational or speech therapist, a hospital or skilled nursing facility or hospice facility, or a home health care agency; and
- Expected to develop impaired function and/or develop speech function as a result of delayed development.

Eligible habilitation health services include:

- Occupational therapy (except for vocational rehabilitation or employment counseling) if it is expected to develop any impaired function;
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development.
 - Speech function is the ability to express thoughts, speak words, and form sentences.

Prosthetic Devices

The Plan covers internal and external prosthetic devices and special appliances. The device or appliance must improve or restore the function of a body part lost or damaged by illness, injury, or congenital defect.

Here are some examples of covered devices:

- An artificial arm, leg, hip, knee, or eye;
- An eye lens;
- An external breast prosthesis and the first bra made solely for use with the prosthesis after a mastectomy;
- A breast implant after a mastectomy; and
- A cardiac pacemaker.

Coverage includes:

- Purchase of the first prosthesis that you need to temporarily or permanently replace an internal body part or organ, or an external body part;
- Instruction and incidental supplies needed to use a covered prosthetic device;
- Replacement of a prosthetic device if:
 - The replacement is needed because of a change in your physical condition or because of normal growth or wear and tear;
 - Replacement is likely to cost less than repairing the existing device; or
 - The existing device cannot be made serviceable.

Radiation Therapy

The Plan covers the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

Spinal Manipulation

The Plan covers manipulative treatment of a condition caused by (or related to) biomechanical or nerve conduction disorders of the spine. Care must be given by a physician or licensed chiropractor in the provider's office. Treatment of scoliosis, of a fracture, or before or after surgery is not covered as a spinal manipulation benefit.

Women's Health Provisions

Federal law affects how certain health conditions are covered by the Plan. Your rights under these laws are described here.

The Newborns' and Mothers' Health Protection Act

Maternity hospital stays under the Plan will be covered for a minimum of 48 hours following a vaginal delivery, or 96 hours for a cesarean section delivery. These minimums are set by a federal law called The Newborns' and Mothers' Protection Act. However, the Plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician's assistant) discharges the mother or newborn earlier, after consulting with the mother.

Other provisions of this law:

- The level of benefits for any portion of the hospital stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the stay.
- The Plan cannot require precertification for a stay of up to 48 or 96 hours, as described above.

The Women's Health and Cancer Rights Act

When a woman who is covered by the Plan decides to have reconstructive surgery after a medically necessary mastectomy, the Women's Health and Cancer Rights Act requires the Plan to cover these procedures:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymphedema. This coverage will be provided in consultation with the attending physician and the patient.

For answers to questions about the Plan's coverage of mastectomies and reconstructive surgery, call Member Services at the number on your ID card.

Behavioral Health Care

The Plan includes coverage for behavioral healthcare.

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers. Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility, or behavioral health provider's office for the treatment of mental disorders as follows:

Inpatient Treatment

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital, or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Precertification Is Required

Inpatient care, partial hospitalizations, and outpatient treatment must be precertified by Aetna. Refer to “[How Medical Coverage Works](#)” on page 47 for more information about precertification.

Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

A plan of medical, psychiatric, nursing, counseling, and/or therapeutic services to treat mental disorders and substance abuse is required. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital, or residential treatment facility on less than a full-time inpatient basis;
- It is in accord with accepted medical practice for the condition of the person;
- It does not require full-time confinement; and.
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital, or residential treatment facility.

The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of substance abuse by behavioral health providers.

Inpatient Treatment

The Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a hospital for the medical complications of substance abuse; and
- “Medical complications” include detoxification, electrolyte imbalances, malnutrition, and cirrhosis of the liver, delirium tremens, and hepatitis.

Treatment in a hospital is covered only when the hospital does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, psychiatric hospital, or residential treatment facility.

The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance abuse.

A plan of medical, psychiatric, nursing, counseling, and/or therapeutic services to treat mental disorders and substance abuse is required. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital, or residential treatment facility on less than a full-time inpatient basis;
- It is in accord with accepted medical practice for the condition of the person;
- It does not require full-time confinement; and
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.

Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Precertification Is Required

Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to “[Precertification](#)” on page 50 for more information.

What Is Not Covered

The medical Plan you are enrolled in does not cover all medical expenses; certain expenses are excluded. The list of excluded expenses in this section is representative, not comprehensive and applies to all of the medical plan options described in this book. Just because a type of medical treatment or an expense is not listed here does not mean that the treatment or expense will be covered.

This section and “[What Is Covered](#)” on page 59 should be read together to learn more about what is covered and not covered under the plan for certain conditions, procedures, services, and supplies.

General Exclusions

The Plan does *not* cover charges:

- For cancelled or missed appointments.
- For care, treatment, services, or supplies:
 - Given by an unlicensed provider; or
 - Outside the scope of the provider’s license.

- For care, treatment, services, or supplies not prescribed, recommended, or approved by a physician or dentist.
- For claim form completion.
- For drugs, devices, treatments or procedures that are experimental or investigational, except as described in “[What Is Covered](#)” on page 59.
- For services and supplies Aetna determines are not necessary for the diagnosis, care, or treatment of the disease or injury involved — even if they are prescribed, recommended, or approved by a physician or dentist.
- For services given by volunteers or persons who do not normally charge for their services.
- For services and supplies provided as part of treatment or care that is not covered by the Plan.
- For services and supplies provided in school, college, or camp infirmaries.
- For services billed by a resident physician or intern.
- For services, supplies, medical care, or treatment given by members of your immediate family (your spouse, domestic partner, child, stepchild, brother, sister, in-law, parent, or grandparent) or your household.
- Incurred before the date coverage starts or after the date coverage ends. This includes charges for admission to a hospital or skilled nursing facility as an inpatient before or after the date of coverage under the Plan. The Plan will cover only the part of the inpatient stay or related services that occurred after the date coverage starts this Plan.
- In excess of the recognized charge for a service or supply given by an out-of-network provider.
- In excess of the negotiated charge for a given service or supply given by an in-network provider.
- In excess of any annual or lifetime maximums specifically outlined.
- Made only because you have health coverage or that you are not legally obligated to pay, such as:
 - Care in charitable institutions that normally provide services free of charge; or
 - Care in a hospital or other facility that is owned or operated by any government that normally provides services free of charge.
- Related to employment or self-employment. This includes injuries that arise out of (or in the course of) any work for pay or profit, unless there is no other source of coverage or reimbursement available to you.
- Resulting from a felony that you commit or attempt to commit; or
- To have preferred access to a physician’s services, such as boutique or concierge physician practices.

Advanced Reproductive Technology (ART)

Unless otherwise specified in the Comprehensive Infertility and ART section above, the following charges will **not** be payable as covered expenses under the UVA Health Plan:

- ART services for a female attempting to become pregnant who has not had at least one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program;
- ART services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- Infertility services for females with FSH levels 19 or greater mIU on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from Aetna's infertility case management unit;
- Infertility Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not infertile.

Alternative Health Care

The Plan does **not** cover charges for:

- Alternative or non-standard allergy services and supplies, including (but not limited to):
 - Cytotoxicity testing (Bryan's Test);
 - Skin titration (wrinkle method);
 - Treatment of non-specific candida sensitivity; and
 - Urine auto injections.
- Aromatherapy.
- Acupressure or hypnotherapy.
- Bioenergetic therapy.

- Biofeedback services.
- Carbon dioxide therapy.
- Herbal medicine and holistic or homeopathic care, including drugs.
- Megavitamin therapy.
- Massage therapy.
- Rolfing.
- Thermography and thermograms.

Behavioral Healthcare

The Plan's Behavioral Healthcare benefit does not cover charges for:

- Applied behavioral analysis (the LEAP, TEACCH, Denver or Rutgers programs) except to any extent specifically described as covered.
- Inpatient or outpatient alcoholism or substance abuse rehabilitation treatment, except to the extent specifically described as covered.
- Treatment by a provider who specializes in the mental healthcare field who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine, or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation defects and deficiencies except to any extent specifically described as covered.

Biological and Bionic

The Plan does *not* cover charges for:

- Artificial organs. The Plan does not cover any device intended to perform the function of a body organ, except when medically necessary to be used as a bridge to transplant for transplant-eligible members who are awaiting permanent transplants.
- Blood, blood plasma, synthetic blood, blood products, or blood substitutes. The Plan does not cover any related services, including:
 - Processing, storage, or replacement costs; or
 - The services of blood donors, apheresis, or plamapheresis.

For autologous blood donations, only administration and processing costs are covered.

- Growth hormones, surgical procedures, or any other treatment, device, drug, service, or supply to increase or decrease height or alter the rate of growth.
- Any service, supply, or treatment using a chelating agent, except to provide treatment for heavy metal poisoning.

Cosmetic Procedures

The Plan does **not** cover the following, regardless of whether the service is provided for psychological or emotional reasons:

- Injection of sclerosing solutions for treatment of varicose veins;
- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, cosmetic eyelid surgery, and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments, or other treatments or supplies to alter the appearance or texture of the skin;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty;
- Plastic surgery;
- Cosmetic surgery; or
- Mammoplasty, other services, treatments, or supplies that improve, alter, or enhance the shape or appearance of the body (such as breast or chin implants) except removal of an implant will be covered when medically necessary.

Criminal Acts

The Plan does **not** cover charges incurred as the result of injuries sustained during the commission of a felony. Incarcerated individuals are not eligible for enrollment in the Plan.

Custodial and Protective Care

The Plan does **not** cover charges for:

- Any item or service that is primarily for the personal comfort and convenience of you or a third party.
- Care provided to create an environment that protects a person against exposure that can make his or her disease or injury worse.
- Care, services, and supplies provided in a:
 - Rest home;
 - Assisted living facility;
 - Health resort, spa, or sanitarium; or
 - Similar institution serving as an individual's primary residence or providing primarily custodial or rest care.
- Custodial care — care provided to help a person in the activities of daily life.

- Maintenance care except for habilitation therapy services for children through age 4. See “[Habilitation Therapy Services for Children Through Age 4](#)” on page 79.
- Removal from your home, workplace, or other environment of potential sources of allergy or illness, including:
 - Asbestos or fiberglass;
 - Carpeting;
 - Dust, pet dander or pests;
 - Mold; or
 - Paint.

Dental Care

Dental Care is covered under the UVA Dental Plan administered by UCCI. The medical Plan does *not* cover services, treatment, or supplies related to the care, filling, removal, or replacement of teeth, including:

- Apicoectomy (dental root resection), root canal therapy, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation, and vestibuloplasty.
- Application of fluoride and other substances to protect, clean, or alter the appearance of teeth.
- Dental implants, false teeth, plates, dentures, braces, mouth guards, or other devices to protect, replace or reposition teeth.
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including:
 - Treatment of malocclusion; and
 - Devices to alter bite or alignment.

Education and Training

The Plan does *not* cover charges for:

- Services or supplies related to education, training, retraining services, or testing, including:
 - Special education;
 - Remedial education;
 - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution);
 - Job training;
 - Job hardening programs; or
 - Educational services, schooling, or any such related or similar program, including therapeutic programs within a school setting.

Family Planning and Maternity

The Plan does **not** cover:

- Home births.
- Home uterine activity monitoring.
- Over-the-counter contraceptive supplies including (but not limited to) condoms and contraceptive foams, jellies, and ointments.
- Reversal of sterilization procedures.
- Interruption of pregnancy unless pregnancy occurs as a result of rape or incest which has been reported to a law enforcement or public health agency or when the mother's life could be endangered by continuing the pregnancy or when a fetus is believed to have a physician-certified incapacitating physical deformity or incapacitating mental deficiency.

Foot Care

The Plan does **not** cover services, supplies, or devices to improve the comfort or appearance of toes, feet, or ankles, including:

- Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, or other equipment, devices, or supplies, even when required after treatment of an illness or injury that was covered by the Plan.
- Treatment of calluses, bunions, toenails, hammertoes, subluxations, fallen arches, weak feet, or chronic foot pain.
- Treatment for conditions caused by routine activities such as walking, running, working, or wearing shoes.

Government and Armed Forces

The Plan does not cover charges — to the extent allowed by law — for services or supplies provided, paid for, or for which benefits are provided or required:

- Because of a person's past or present service in the armed forces of a government.
- Under any government law.

Health Exams

The Plan covers exams that are necessary to treat illness or injury, and routine preventive exams specifically described as covered. The Plan does **not** cover exams or related reports (including report presentation and preparation) required:

- By any government law.
- By a third party, including exams to obtain or maintain employment, or which an employer must provide under a labor agreement.
- For professional or other licenses.
- To obtain insurance.
- To travel; attend a school, camp, or sporting event; or participate in a sport or other recreational activity.

Home and Mobility

The Plan does not cover alterations or additions to your home, workplace, or other environment, or any related equipment or device, including (but not limited to):

- Bathroom equipment such as tub seats, benches, rails, and lifts.
- Equipment or supplies to help you sit or sleep, such as electric beds, water beds, air beds, warming or cooling devices, elevating chairs, and reclining chairs.
- Exercise and training devices, whirlpools, sauna baths, massage devices, or over-bed tables.
- Purchase or rental of air purifiers, air conditioners, water purifiers, or swimming pools.
- Room additions or changes to countertops, doorways, lighting, wiring, or furniture.
- Stair glides, wheelchair ramps, and elevators.

The Plan does not cover vehicles and transportation devices, or alterations to any vehicle or transportation device, including:

- Automobiles, vans, or trucks;
- Bicycles;
- Stair-climbing wheelchairs; and
- Personal transporters.

Home Health Care

The Plan does ***not*** cover home healthcare related to:

- Custodial Care, even if the care is provided by a nursing professional when family members or other caretakers cannot provide necessary care;
- Private duty nursing; and
- Care that is not part of a home healthcare plan.

Hospice Care

The Plan's hospice care benefit does ***not*** include coverage for:

- Private or special nursing services;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling, including estate planning and the drafting of a will; and
- Homemaker or caretaker services. These are services not entirely related to the care of a patient and include sitter or companion services for the patient or other family members, transportation, housecleaning, and home maintenance.

Infusion Therapy

The Plan does **not** cover the following as infusion therapy:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Oral Surgery

Except as described above to treat accidental injury, the Plan does **not** cover charges:

- For dental-in-nature oral surgery expenses;
- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain;
- For root canal therapy;
- To remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace, or restore fillings, crowns, dentures, or bridgework;
- For periodontal treatment;
- For dental cleaning, in-mouth scaling, planning, or scraping; or
- For myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

Outpatient Short-Term Rehabilitation

The Plan's outpatient short-term rehabilitation benefit does not include coverage for:

- Therapies for treatment of delays in development except to any extent specifically described as covered, unless resulting from acute illness or injury, or from congenital defects that are amenable to surgical repair. Therapies to treat pervasive developmental disorders, Downs syndrome and cerebral palsy, for example, are not covered because these conditions are both developmental and/or chronic. This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders or Habilitation Therapy.
- Any services unless provided in accordance with a specific treatment plan.
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above.
- Services provided by a home healthcare agency.
- Services not performed by a physician or under the direct supervision of a physician.
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section.

- Services provided by a physician or physical, occupational or speech therapist who resides in your home or who is a member of your family, or a member of your spouse's family.
- Care provided by a family member.
- Treatment for delays in speech development not resulting from disease, injury, or congenital defect.
- Special education to teach someone who has lost the ability to speak how to function without speech, including sign language lessons.

Prescription Drugs

Prescription drugs are covered under the Prescription Drug Program administered by OptumRx. The medical Plan covers prescription drugs provided while you are a hospital inpatient. The medical Plan does **not** cover:

- Any prescription drug you obtain on an outpatient basis. Refer to “[OptumRx Prescription Drug Program](#)” on page 95 for information about coverage for drugs you obtain from a retail pharmacy or through the mail order drug program.
- Diabetic products, needles, and syringes.
- Immunizations related to travel or work.
- Implantable drugs and associated devices, except contraceptive implants and IUDs. Diaphragms, cervical caps, and injectable contraceptives are not covered.
- Injectable drugs if an oral alternative is available.
- Needles, syringes, and other injectable aids.
- Nutritional supplements.
- Over-the-counter drugs, biologicals, or chemical preparations that can be obtained without a prescription.
- Performance-enhancing steroids.
- Self-injectable drugs.

Reproductive and Sexual Health

The Prescription Drug Program administered by OptumRx covers some reproductive and sexual health prescription drugs. Refer to “[OptumRx Prescription Drug Program](#)” on page 95 for coverage information. The medical Plan does **not** cover charges for:

- Drugs to treat erectile dysfunction, impotence, or sexual dysfunction or inadequacy, whether delivered in oral, injectable or topical forms. These include, but are not limited to:
 - Alprostadil (Muse, Edex, Caverject);
 - Phenotolamine;
 - Sildenafil citrate (Viagra);
 - Tadalafil (Cialis);
 - Vardenafil (Levitra); and
 - Any other drug in a similar or identical class that has a similar or identical mode of action or produces similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical forms (including but not limited to gels, creams, ointments, and patches).

- Supplies for sexual dysfunction or inadequacies with no physiological or organic basis.
- Except as covered under the section of Transgender Reassignment, treatment, drugs, services, or supplies related to changing sex or sexual characteristics, including:
 - Surgical procedures to alter the function or appearance of the body;
 - Hormones or hormone therapy; and
 - Prosthetic devices.
- Treatment, drugs, services, or supplies to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including:
 - Surgery, drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sexual organ;
 - ICD-10 terminology to exclude coverage for sexual dysfunctions not due to a substance or known physiological condition” which includes hypoactive sexual desire, sexual aversion disorder, sexual arousal disorders (male and female), orgasmic disorder, premature ejaculation, vaginismus, dyspareunia, “other” and “unspecified”; and
 - Sex therapy, sex counseling, or marriage counseling.

Routine Physical Exam

The Plan does **not** cover the following in connection with a routine physical exam:

- Medicines, drugs, appliances, equipment, or supplies;
- Immunizations required solely for travel or employment;
- Psychiatric, psychological, personality, or emotional testing or exams;
- Premarital exams;
- Routine hearing screenings performed with equipment or calibrated instruments, except for newborns;
- Routine vision screenings.

Strength and Performance

The Plan does **not** cover services, devices and supplies to enhance your strength, physical condition, endurance, or physical performance, including:

- Drugs or preparations to enhance strength, performance, or endurance.
- Exercise equipment.
- Lifestyle enhancement drugs or supplies.
- Memberships in health or fitness clubs.
- Training, advice, or coaching.
- Treatments, services, and supplies to treat illness, injury, or disability related to the use of performance-enhancing drugs or preparations.

Tests and Therapies

The Plan does **not** cover charges for:

- Full-body CAT scans;
- Hair analysis;
- Hyperbaric therapy, except to treat decompression or promote healing of a wound; and
- Sleep therapy.

Transplants

As part of the transplant benefit, the Plan does **not** cover:

- Services and supplies provided to a donor when the recipient is not covered by this Plan;
- Outpatient drugs including biomedical and immunosuppressants that are not expressly related to an outpatient transplant occurrence;
- Home infusion therapy after the transplant coverage period ends;
- Harvesting or storage of organs without the expectation of an immediate transplant for an existing illness; or
- Harvesting or storage of bone marrow, tissue, or stem cells without the expectation of a transplant to treat an existing illness within 12 months.

Travel and Transportation

The Plan does **not** cover travel and transportation expenses even if prescribed by a physician, except ambulance services specifically described as covered. Medical evacuation and repatriation are not covered.

Vision, Speech and Hearing

The Plan does **not** cover charges for:

- Anti-reflective coatings and tinting of eyeglass lenses.
- Contact lenses.
- Eyeglasses, including duplicate or spare glasses, lenses, or frames.
- Eye surgery to correct vision, including radial keratotomy, LASIK, and similar procedures.
- Fitting of eyeglasses or contact lenses for any purpose other than:
 - after cataract surgery;
 - for keratoconus or other corneal disorders associated with irregular astigmatism; or
 - when used for treatment of severe ocular surface diseases.
- Hearing aids and their fitting, and hearing aid therapy or training.
- Replacement of lenses or frames that are lost, stolen, or broken.

- Routine vision or hearing exams except for newborn hearing screenings.
- Special services, such as non-prescription sunglasses and subnormal vision aids.
- Special vision procedures, such as orthoptics, vision therapy, or vision training.
- Vision services mainly to correct refractive errors.

Weight Control Services

Regardless of the existence of comorbid conditions, the Plan does **not** cover charges for weight control, except as described in *Bariatric Surgery*. The Plan does **not** cover charges for:

- Weight control/loss programs;
- Dietary regimens and supplements;
- Appetite suppressants and other medications;
- Food or food supplements; or
- Exercise programs or equipment.

OptumRx Prescription Drug Program

Coverage for FDA-approved prescription drugs is an important part of your healthcare coverage. If you are enrolled in a medical plan, the prescription drug program administered by OptumRx covers prescription drugs that are to be taken on an outpatient basis. Drugs that you need while you are confined in a hospital or other covered healthcare facility may be covered as part of your inpatient medical benefit. Drug program forms and documents are available at www.optumrx.com/ and <https://hr.virginia.edu/>.

You have two ways to fill a prescription:

- At a retail pharmacy; or
- By mail order, through OptumRx Home Delivery.

Benefit Levels

The Schedule of Benefits (see “[Your UVA Medical Coverage Options](#)” on page 28), shows the copay or coinsurance that applies to each type of drug covered under the prescription drug program:

- Tier 1 drugs (most generics and some cost-effective branded medications)
- Tier 2 drugs (most brand name drugs and the more costly or less desirable generics)
- Tier 3 drugs (non-preferred brand drugs and some more costly generics)

Generic and Brand-Name Drugs

To save money, consider using generic drugs. Generic drugs are approved by the U.S. Food and Drug Administration, which means that a generic drug has the same quality, strength, and effectiveness as the brand-name equivalent. You can ask your doctor to prescribe a generic drug or ask your pharmacist if there is a generic drug that is equal to the brand name drug your doctor prescribed. The Plan mandates generic substitution. Coverage is limited to the cost of the generic drug when one is available.

Keep in Mind

If you purchase a brand-name drug when a generic drug is available, you will be responsible for the applicable coinsurance, plus the difference between the cost of the brand-name drug and the cost of the generic drug.

What is the Formulary?

The Formulary is a list of prescribed medications or other pharmacy care products, services, or supplies chosen for their safety, cost, and effectiveness. Medications are listed by categories or classes and are placed into cost levels known as tiers. It includes both brand and generic prescription medications. You may be able to reduce your out-of-pocket expense by using a covered tier 1 or tier 2 drug. The amount you pay will be highest if your physician prescribes a covered tier 3 drug.

You can find the Formulary online at www.optumrx.com. You can also call the toll-free number on your ID card to review the drugs included on the list.

Retail Pharmacy**Preferred Pharmacy**

The OptumRx pharmacy network provides broad access to pharmacy services. When you use a participating pharmacy, you may receive up to a 90-day supply of your prescription at three times the 30-day cost sharing amount.

Show your ID card and pay the applicable copay or coinsurance at the time of your purchase. There are no claim forms to fill out.

You can find a list of preferred pharmacies at www.optumrx.com.

Non-Preferred Pharmacy

You also may fill prescriptions at non-preferred (or non-participating) pharmacies. You'll have to pay the full cost of the prescription and file a claim to be reimbursed for all but the applicable copay or coinsurance. You will also be responsible for other charges outside of the network allowable charge.

Mail Order Prescriptions

If you take medications on a regular basis for a chronic (ongoing) condition, you may order up to a 90-day supply through the OptumRx Home Delivery. Your prescription medications will be delivered to your door.

To begin receiving mail service prescriptions, you must first enroll in one of three ways:

- By mail: Complete a Registration and Prescription Order Form and send it following the instructions on the form.
- Online: Enroll through www.optumrx.com.
- By telephone: Call 877-629-3123 Monday through Friday from 8:00 a.m. to 10:00 p.m. ET or Saturday from 9:00 a.m. to 5:00 p.m. ET.

To order, send your original prescription, together with the special-order form and a check, money order, or credit card number for the applicable copayment or coinsurance, to OptumRx. Order forms are available at www.optumrx.com or by calling OptumRx Member Service Department at 877-629-3123.

Once you are enrolled and your prescription is established, you may obtain refills by mailing the refill request slip provided with every order, by calling 877-629-3123, or via the “Mail Service” link at www.optumrx.com.

Prior Authorization

Some medications such as acne products, ADHD stimulants, and compounds may require prior authorization. If a prior authorization is necessary, your physician must contact OptumRx on your behalf to initiate the request.

Appropriate forms for medication review are available at www.optumrx.com or by calling the OptumRx Member Service Department at 877-629-3123.

Specialty Drug Management Program

The OptumRx Specialty Drug Management Program classifies some medications as specialty drugs. Specialty drugs include those generally characterized as expensive biotech drugs with limited access, complicated treatment regimens, special storage requirements, and/or manufacturer reporting requirements.

Specialty drugs are limited to a 30-day supply and must be filled through the UVA Specialty Pharmacy. Your medication can be delivered to your home or physician’s office. You can contact UVA Specialty Pharmacy at 434-297-5500 for information. Specialty medications may require prior authorization to ensure they are used appropriately and may be subject to quantity limits and step therapy. A list of specialty drugs that are available through the Specialty Drug Management Program can be found at www.optumrx.com or by calling OptumRx Member Service Department at 877-629-3123.

Step Therapy Program

The prescription drug program includes a step-therapy program for individuals who take prescription drugs regularly to treat an on-going medical condition such as arthritis, asthma, or high blood pressure. With an individual’s doctor prescribing all medications, the program plans a path to providing safe, effective treatment at costs as low as possible.

The program usually starts with generic drugs as a first step. If you’ve already tried a generic drug and are unable to take it (due to an allergy, for example) or there is a medical reason you need a brand-name drug, your doctor can request prior authorization for you to take a second step drug. If the prior authorization is approved, you pay the appropriate coinsurance for the drug. If it is not approved, you will be required to pay the full price for the drug.

Quantity Management Program

This program ensures that prescribed quantities are safe, consistent with clinical dosing guidelines, and used appropriately. Quantities in excess of established limits will require a prior authorization.

If your prescription is written for a larger quantity than the plan covers:

- You may ask your pharmacist to fill the prescription within the quantity limits;
- Your pharmacist may ask your doctor to change your prescription to a higher strength, if one is available; or
- Your doctor may request a prior authorization from an OptumRx Clinical Expert to discuss how your medical condition requires quantities beyond FDA-recommended guidelines.

Preventive Medications List

The prescription drug program includes special coverage for preventive medications. These medications help protect against or manage a medical condition such as:

- Preventing blood clots and reducing the risk of a stroke;
- Preventing heart disease and reducing high blood pressure; or
- Preventing osteoporosis.

Taking preventive medication as told by your healthcare provider can help you avoid serious illness and high healthcare costs. The drugs on the preventive medication list do not have a deductible. This means you'll save money by only paying your copayment or coinsurance to get the medications you need to help you live a healthier life.

Covered Drugs

The Plan covers:

- FDA-approved Federal legend drugs (drugs that require a label stating: "Caution: Federal law prohibits dispensing without prescription") or any other FDA- approved drug which under the applicable state law may be dispensed only upon the written prescription of a physician;
- Compounded medication, of which at least one ingredient is a federal legend drug;
- Contraceptives (oral, emergency, injectable, and devices including diaphragms and cervical caps);
- Diabetic products, needles, and syringes;
- Insulin;
- Injectables, including but not limited to, growth hormones and blood products; and
- Smoking cessation aids.

What the Prescription Drug Program Does Not Cover

The prescription drug program does *not* cover the following prescription drug expenses:

- Administration or injection of any drug;
- Any drug dispensed by a mail order pharmacy other OptumRx Home Delivery;

- Any drug not covered by the formulary;
- Any drug that does not, by federal or state law, require a prescription, such as an over-the-counter drug or equivalent over-the-counter product, even when a prescription is written for it except those preventive drugs required by the Affordable Care Act;
- Any prescribed drug that is also available over-the-counter or that has an equivalent over-the-counter product;
- Any refill of a drug dispensed more than one year after the latest prescription for it, or as prohibited by law where the drug is dispensed;
- Drugs or medicines prescribed or dispensed by any person in a Participant's immediate family, defined as including parents, siblings, spouses, children, grandparents, aunts, uncles, nieces, and nephews;
- Drugs or medicines prescribed or dispensed by the Participant themselves;
- Experimental or investigational drugs;
- Inpatient drugs: Any drug provided by a healthcare facility or while you are an inpatient there. Also, any drug provided on an outpatient basis by a healthcare facility if benefits are paid for it under any other part of this Plan or another plan sponsored by your employer;
- Travel-related drugs, medicines, or immunizations;
- Non-sedating antihistamines;
- Vitamins and diet pills;
- Nutritional prescription formulas and supplements;
- Herbal medication;
- Weight loss or eating disorder drugs;
- Cosmetic alteration drugs;
- Surgical supplies and medical devices;
- Diagnostic Agents;
- General Anesthetics;
- Bulk chemicals;
- Over-the-counter drugs;
- Insulin pump & pump supplies;
- Respiratory therapy supplies;
- Immunizations; and
- Compound drugs that contain bulk chemicals.

Drugs Available Under the Discount Benefit Price Structure

Certain drugs that are excluded under the Plan may be dispensed with 100% member cost sharing under the discount benefit price structure. The Plan pays nothing towards these uncovered drugs. The member receives the benefit of OptumRx's negotiated prices when they pay the full cost of these drugs including but not limited to:

- Drugs or medicines (other than injectable insulin) that can be purchased without a physician's prescription including non-sedating antihistamines;
- Vitamins and diet pills;
- Nutritional prescription formulas and supplements;
- Drugs not considered medically necessary, including psoralens and tretinoin (retin-A) for cosmetic use, minoxidil lotion (Rogaine), and nystatin oral powder; and
- Travel-related drugs, medicines, or immunizations.

Aetna Medical Claims and Appeals

The Plan has procedures for submitting medical claims, making decisions on claims, and filing an appeal when you don't agree with a claim decision. You and Aetna must meet certain deadlines that are assigned to each step of the process, depending on the type of claim.

Types of Claims

To understand the claim and appeal process, you need to understand how claims are defined:

- **Urgent care claim:** A claim for medical care or treatment where delay could seriously jeopardize your life or health, or your ability to regain maximum function; or subject you to severe pain that cannot be adequately managed without the requested care or treatment. If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.
- **Pre-service claim:** A claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (precertification).
- **Concurrent care claim extension:** A request to extend a course of treatment that was previously approved.
- **Concurrent care claim reduction or termination:** A decision to reduce or terminate a course of treatment that was previously approved.
- **Post-service claim:** A claim for a benefit that is not a pre-service claim.

Keeping Records of Expenses

It is important to keep records of medical expenses for yourself and your covered dependents. You will need these records when you file a claim for benefits. Be sure you have this information for your medical records:

- Name and address of physicians;
- Dates on which each expense was incurred; and
- Copies of all bills and receipts.

Filing Claims

If you use an out-of-network provider, you must file a claim to be reimbursed for covered expenses. You can obtain a claim form from Aetna Member Services by calling the number on the back of your ID card, or by going online at www.aetna.com. The form has instructions on how, when, and where to file a claim.

File your claims promptly — ***the filing deadline is 90 days after the date you incur a covered expense.*** If, through no fault of your own, you are unable to meet that deadline, your claim will be accepted if you file it as soon as possible. Claims filed more than 12 months after the claim date will be accepted only if you had been legally incapacitated.

You may file claims and appeals yourself or through an “authorized representative,” who is someone you authorize in writing to act on your behalf. In a case involving urgent care, a healthcare professional with knowledge of your condition may always act as your authorized representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures.

Physical Exams

Aetna has the right to require an exam of any person for whom precertification or benefits have been requested. The exam will be done at any reasonable time while precertification or a claim for benefits is pending or under review. The exam may be performed by a doctor or dentist Aetna has chosen, and it will be done at Aetna’s expense.

Time Frames for Claim Processing

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an urgent care claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision no later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Predeterminations

Predeterminations refer to the clinical review of a service that is provided prior to the delivery of a service when the service or procedure does not require precertification or preauthorization. Predeterminations are not considered claims (pre-service or post-service) and are not subject to the appeal and external review rights as described for a precertification determination or a post service claims determination.

A predetermination is eligible for one internal reconsideration.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an adverse benefit determination relating to service(s) you have received or could have received from your healthcare provider under the Plan.

An "adverse benefit determination" is a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit. An adverse benefit determination may be based on:

- Your ineligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not medically necessary.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under any applicable law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna’s or the Plan’s or its designee’s control; and
- It was part of an ongoing good faith exchange between you and Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna which must then be provided within 10 days and include a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for refiling the claim begin to run upon receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna’s Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this booklet). Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your healthcare provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an adverse benefit determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your identification card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Health Claims – Voluntary Appeals

External Review

“External review” is a review of an adverse benefit determination or a final internal adverse benefit determination by an Independent Review Organization/External Review Organization (ERO).

A “final external review decision” is a determination by an ERO at the conclusion of an external review.

You must complete all of the levels of standard appeal described above before you can request external review, other than in a case of deemed exhaustion. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for external review of any adverse benefit determination or any final internal adverse benefit determination that qualifies as set forth below.

The notice of adverse benefit determination or final internal adverse benefit determination that you receive from Aetna will describe the process to follow if you wish to pursue an external review and will include a copy of the Request for *External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the adverse benefit determination or final internal adverse benefit determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be followed while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary, and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The external review process under this Plan gives you the opportunity to receive review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to applicable law. Your request will be eligible for external review if the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage, which has retroactive effect.

An adverse benefit determination based upon your eligibility is not eligible for external review.

If upon the final standard level of appeal, the coverage denial is upheld, and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless deemed exhaustion applies), and you have provided all paperwork necessary to complete the external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for external review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the external review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for external review and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the external review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending healthcare professional's recommendation;
- Reports from appropriate healthcare professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the final external review decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of final external review decision to you, Aetna and the Plan.

After a final external review decision, the ERO must maintain records of all claims and notices associated with the external review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review, decision reversing the Adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited external review at the time you receive:

- An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard external review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for external review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Claim Fiduciary

Claim decisions are made by the Claim Fiduciary in accordance with the provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Interpret the provisions of the Plan when a question arises.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily or capriciously, which would be an abuse of its discretionary authority.

Aetna is the Claim Fiduciary for the Plan and has discretionary authority to review all denied claims for benefits under the Plan.

The University is responsible for making reports and disclosures, including the creation, distribution, and final content of:

- Summary Plan Descriptions;
- Summary of material modifications; and
- Schedule of Benefits.

Complaints

The Plan has procedures for you to follow if you are dissatisfied with the service you receive from the Plan or you want to complain about an in-network provider. To make a complaint about an operational issue or the quality of care you've received, you must write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant. Aetna will review the information and give you a written decision within 30 calendar days of the receipt of the complaint, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will tell you what you need to do to seek an additional review.

Recovery of Overpayment

When Aetna identifies an overpayment, it notifies the provider of the overpayment and provides the provider with the opportunity to dispute the overpayment. Aetna also informs the provider that Aetna will offset the overpayment from a future claim payment if a dispute is not received. Here are the next steps in the process:

1. If there is no dispute by the provider and no other restriction, then Aetna may offset the overpayment against a later payment to that provider. Indeed, some providers prefer the convenience of offsetting an overpayment against the next payment. Aetna conducts frequent reconciliations with providers to ensure we are paying providers the correct amounts across our book of business.
2. If certain claims are in overpayment status with a certain provider, Aetna will offset future payments owed to that provider in the amounts of those overpayments.
3. If Aetna recovers an overpayment from a provider on behalf of a plan, it will separately credit the plan that made the overpayment for recovery of the overpayment. **The credit for the overpayment and the payment of claims are all *separate* transactions and are reflected as such in Aetna's accounting systems.**

No legal action can be brought to recover a benefit after three (3) years from the deadline for filing claims.

OptumRx Prescription Drug Claims and Appeals

Review of an Adverse Benefit Determination

Most questions or concerns about decisions made on claims or requests for benefits can be resolved by calling one of the OptumRx member service representatives at 877-629-3123.

You may request review of an adverse benefit determination. An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial based on your eligibility to participate in your employer's health plan.

If you are not completely satisfied with OptumRx's initial customer service response and determination, you must submit this concern in writing to begin the appeal process. An appeal is a written request for review of an adjudicated claim or related item. To obtain review of an adverse benefit determination, you must follow the review procedures below.

Review Procedure

To initiate the Standard Internal Appeal review, you or your authorized representative must send OptumRx a written statement explaining why you disagree with the determination. Include in your request all documentation, records or comments you believe support your position. You must file your appeal within 180 days of the date you were notified of the adverse benefit decision. This can be initiated by contacting OptumRx Member Services at 1-877-629-3123 or by completing the appeal form sent to you with your denial letter.

Mail the completed form and supporting documents to: OptumRx Appeal Department, OptumRx, P.O. Box 371544, Las Vegas, NV 89134. You can also fax your written request for review to 1-888-826-7406, Attn. OptumRx Appeal Department. OptumRx will respond to your request for review in writing within 30 days, unless they have notified you in writing that additional information is needed to complete the review.

Upon receiving a Standard Internal Appeal, an OptumRx clinical pharmacist will review the Standard Internal Appeal. If the clinical pharmacist does not overturn the initial adverse benefit determination, OptumRx will forward the Standard Internal Appeal to a physician and/or an Independent Review Organization (IRO) for further review, provided that any such physician or IRO is neither the individual who made any previous Adverse Determination.

If the initial adverse benefit determination is overturned by the clinical pharmacist, physician or IRO, then the decision will be implemented, and OptumRx will notify the Plan Participant, his or her representative, and/or Prescriber (as applicable) of the favorable determination in writing.

If the initial adverse benefit determination is not overturned by the clinical pharmacist, physician or IRO, then OptumRx will notify the Plan Participant, his or her representative, or Prescriber (as applicable) of the adverse determination in writing.

If your claim is still denied after this initial review because it was determined that the drug is not appropriate or is experimental or investigative in nature, you may submit a written request for an external review. Contact OptumRx by fax at 1-888-826-7406 within four months of your receipt of the internal review decision to initiate the external review. If your external review request is complete and eligible for external review, OptumRx will submit your appeals file to an Independent Review Organization (IRO) in accordance with the procedures established by applicable law. The IRO will review all the information and documents related to the adverse benefit determination and will provide you with a written notice of the decision within 45 days of its receipt of the request for external review.

Administrative Information

This section includes information about the administration of the Plan described in this Summary Plan Description. While you may not need this information for your day-to-day participation, it is information you may find important from time to time.

Plan Information

Plan Name

The University of Virginia Health Plan

Employer Identification Number (EIN)

54-6001796

Plan Number

501

Plan Sponsor

The University of Virginia
2420 Old Ivy Road
P.O. Box 400127
Charlottesville, VA 22904-4127
434-243-3344

Type of Plan

Self-funded welfare plan

Plan Year

January 1 — December 31

Medical and Behavioral Health Claims Administrator

Aetna
151 Farmington Avenue
Hartford, CT 06156
800-987-9072

Prescription Benefit Manager

OptumRx
11000 Optum Circle
Eden Prairie, MN 55344
877-629-3123

Plan Documents

This is the official Plan document that governs the Plan and is also known as the Summary Plan Description for the Plan (this book). The Plan document governs the Plan. Copies of this document are available for your inspection during regular business hours in the office of the Plan Sponsor. You (or your personal representative) may obtain a copy of these documents by downloading them from the UVA HR website: <https://hr.virginia.edu/> or by written request to the Plan Sponsor, for a nominal charge.

Interpretation of Eligibility Rules

The Plan Sponsor shall have the exclusive right to interpret the meaning of any description of eligibility, enrollment, and payment rules.

Future of the Plan

Although the University expects to continue the Plan described in this book indefinitely, it necessarily reserves the right to discontinue the Plan or to implement any changes to it at any time, and for any reason, at the sole determination of the University.

The University may amend, modify, revoke or terminate the Plan at any time, as it may determine in its sole discretion. The University's decision to terminate or end the Plan may be due to changes in federal or state laws governing employee benefits or the requirements of the Internal Revenue Service. A Plan change may transfer Plan assets and debts to another plan or split the Plan into two or more parts. If the University does change or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

If the Plan is terminated, neither active nor retired employees will have the right to any other benefits from the terminated Plan, other than for those claims incurred prior to the date of termination or as provided by the individual contracts. In addition, if the Plan is amended, all covered persons — active, retired or dependents — may be subject to altered coverage and benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the plans and decisions by the University. After all benefits have been paid and other requirements of the law have been met, remaining Plan assets will be turned over to the University.

Non-Discrimination

The University of Virginia Health Plan and Aetna comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan and Aetna do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UVA Health Plan and Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the University of Virginia Health Plan Privacy Officer, (434) 924-4346, at AskHR@virginia.edu, or by mail: Attention Health Plan Privacy Officer, 2420 Old Ivy Road, P.O. Box 400127, Charlottesville, VA 22904-4127.

If you believe that UVA Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the UVA Privacy Officer, (434) 924-4346, at AskHR@virginia.edu, or by mail: Attention Health Plan Privacy Officer, 2420 Old Ivy Road, P.O. Box 400127, Charlottesville, VA 22904-4127.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Privacy of Your Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

University of Virginia's Plan's Commitment to Privacy

The University of Virginia Health Plan and the University of Virginia Dental Plan (collectively referred to as the "Plan") are committed to protecting the privacy of your protected health information. Protected health information, which is referred to as "health information" in this Notice, is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. The Plan creates, receives, and maintains your health information when it provides health, dental, prescription drug, and medical flexible spending account benefits to you and your eligible dependents. The Plan also pledges to provide you with certain rights related to your health information.

By this Notice of Privacy Practices ("Notice"), the Plan informs you that it has the following legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice of its legal duties and privacy practices with respect to your health information;
- to abide by the terms of this Notice currently in effect; and
- to provide you with notice of breaches of your health information as required by federal health privacy or other laws.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "yours" refers to insured participants and eligible dependents.

This Notice was initially effective as of April 14, 2003. This notice was revised effective January 1, 2013, September 1, 2013, January 1, 2014, January 1, 2016, and January 1, 2017.

Information Subject to this Notice

The Plan creates, receives, and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and healthcare professionals, and from reports and data provided to the Plan by healthcare service providers, insurance companies, and other third parties. The health information the Plan has about you includes, among other things, your name, address, phone number, birthdate, social security number, and medical and health claims information. This is the information that is subject to the privacy practices described in this Notice.

This Notice does not apply to health information created, received, or maintained by the University of Virginia on behalf of the non-health employee benefits that it sponsors, such as disability benefits and life insurance benefits. This Notice also does not apply to health information that the University of Virginia requests, receives, and maintains about you for employment purposes, such as employment testing, or determining your eligibility for medical leave benefits or disability accommodations.

Summary of the Plan's Privacy Practices

The Plan's Uses and Disclosures of Your Health Information

Generally, you must provide a written authorization to the Plan for it to use or disclose your health information. However, the Plan may use and disclose your health information without your authorization for the administration of the Plan and for processing claims. The Plan also may use and disclose your health information without your authorization for other purposes as permitted by the federal health privacy law, such as health and safety, law enforcement or emergency purposes. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- File a complaint with the Plan or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices or about this Notice, if you wish to obtain additional information about the Plan's privacy practices, or if you wish to submit a complaint, please contact:

Privacy Officer
2420 Old Ivy Road
P.O. Box 400127
Charlottesville, VA 22904-4127
434-924-4346

Detailed Notice of the Plan's Privacy Policies – the Plan's Uses and Disclosures

Except as described in this section, as provided for by the federal health privacy law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and the processing of health claims. The uses and disclosures that do not require your written authorization are described below.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

- For Treatment. The Plan may disclose your health information to a healthcare provider, such as a hospital or physician, to assist the provider in treating you.
- For Payment. The Plan may use and disclose your health information without your authorization so that your claims for healthcare services can be paid according to the Plan's terms. For example, the Plan may use and disclose your health information to determine whether certain healthcare services that you seek are covered by the Plan or to process your healthcare claims. The Plan also may disclose your health information to coordinate payment of your healthcare with others who may be responsible for certain costs.

- For Health Care Operations. The Plan may use and disclose your health information without your authorization so that it can operate efficiently and in the best interests of its participants. For example, the Plan may disclose your health information for underwriting purposes, for business planning purposes, or to attorneys who are providing legal services to the Plan. The Health Plan may not use or disclose PHI that is genetic information for any underwriting purposes per GINA rules (Genetic Information Nondiscrimination Act).

Uses and Disclosures to Business Associates

The Plan may disclose certain of your health information without your authorization to its "business associates," which are third parties that assist the Plan in its operations. For example, the Plan may share your claims information with a business associate that provides claims processing services to the Plan, and the Plan may disclose your health information to its business associates for actuarial projection and audit purposes, and legal services. The Plan enters contracts with its business associates requiring that the privacy your health information be protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information, without your authorization, to the Plan Sponsor, which is the University of Virginia, for plan administration purposes, such as performing quality assurance functions, and for monitoring and auditing functions. The Plan Sponsor will certify to the Plan that it will protect the privacy of your health information and that it has amended the plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

The federal health privacy law provides for specific uses or disclosures of your health information that the Plan may make without your authorization, some of which are described below.

- Required by Law. The Plan may use and disclose health information about you as required by the law. For example, the Plan may disclose your health information for the following purposes: for judicial and administrative proceedings pursuant to legal process and authority; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.
- Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury, or disability.
- Government Functions. Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the healthcare system for audits, investigations licensure, and other oversight activities.
- Active Members of the Military and Veterans. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
- Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.
- Emergency Situations. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

- **Involved Family and Friends.** We may disclose health information about you to a relative, a friend, or other person involved in your healthcare or payment for your healthcare, such as the subscriber of your health benefits plan, provided the information is directly relevant to that person's involvement with your healthcare or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Member Services number on your ID card. To authorize disclosures to a relative or other person, call the toll-free Member Services number on your ID card for release of information from the Third Party Administrator, and the Privacy Office at 434.924.4346 for release of information from the UVA Health Plan. If you are deceased, the Plan may disclose your health information to such individuals involved in your care or payment for your healthcare prior to your death the health information that is relevant to the individual's involvement, unless you have previously instructed the Plan otherwise.
- **Personal Representatives.** Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a relationship with you that gives them the right to act on your behalf. Examples of personal representatives are parents for minors and those who have Power of Attorney for adults.
- **Treatment and Health-Related Benefits Information.** The Plan and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services, and medication.
- **Research.** Under certain circumstances, the Plan may use or disclose your health information for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.
- **Organ and Tissue Donation.** If you are an organ donor, the Plan may use or disclose your health information to an organ donor or procurement organization to facilitate an organ or tissue donation transplantation
- **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan does not use your health information for fundraising or marketing purposes and does not sell your protected health information.

Any Other Uses and Disclosures Require Your Express Written Authorization

Uses and disclosures of your health information other than those described above or otherwise allowed by the federal health privacy law will be made only with your express written authorization. Your written authorization is also required for most uses or disclosures of psychotherapy notes (where appropriate). You may revoke your authorization in writing. If you do so, the Plan will not use or disclose your health information authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization.

Once your health information has been disclosed pursuant to your authorization, the federal health privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plan's knowledge or authorization.

Your Health Information Rights

You have the following rights regarding your health information that the Plan creates, receives and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

Privacy Officer
2420 Old Ivy Road
P.O. Box 400127
Charlottesville, VA 22904-4127

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health information that is maintained by the Plan. This includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy health information maintained by the Plan, submit a written request to the Privacy Officer. The Plan may charge a fee for the cost of copying and/or mailing the health information that you have requested. In limited instances, the Plan may deny your request to inspect and copy your health information. If that occurs, the Plan will inform you in writing. In addition, in certain circumstances, if you are denied access to your health information, you may request a review of the denial.

If your request for access is granted, then the Plan will provide you with access to your health information in the form and format you requested, if it is readily producible in such form or format; if it is not readily producible, then access will be provided in a mutually agreed upon form and format.

Right to Request That Your Health Information Be Amended

You have the right to request that the Plan amend your health information if you believe the information is incorrect or incomplete.

To request an amendment, submit a written request to the Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:

- Was not created by or for the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of your health information maintained by or for the Plan;
- Is not part of the health information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures, which is a list of certain disclosures of your health information by the Plan to others. Generally, the following disclosures are not part of an accounting: disclosures that occur before April 14, 2003; disclosures for treatment, payment, or healthcare operations; disclosures made to or authorized by you; and certain other disclosures. The accounting covers up to six years prior to the date of your request (but not disclosures made before April 14, 2003).

To request an accounting of disclosures, submit a written request to the Privacy Officer. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, the Plan may charge you for the cost of providing the accounting. But, the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your healthcare information that the Plan uses or discloses about you to carry out treatment, payment, or healthcare operations. You also have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the Privacy Officer that explains what information you wish to limit, and how and/or to whom you would like the limits to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions. To restrict access to your online health information by the subscriber of your health policy, contact Aetna Customer Service at 1-800-887-9072.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that the Plan communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plan only contact you at work or by mail, or that the Plan provide you with access to your health information at a specific, reasonable location.

To request confidential communications by alternative means or at an alternative location, submit a written request to the Privacy Officer. Your written request should state the reason(s) for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of your health information by non-confidential communications could endanger you. The Plan will accommodate reasonable requests and notify you appropriately.

Right to File a Complaint

You have the right to complain to the Plan and/or to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the Privacy Officer named above.

You will not be retaliated or discriminated against and no services, payment, benefits, or privileges will be withheld from you because you file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the Privacy Officer named above.

Changes in the Plan's Privacy Policies

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including your protected health information that it created or received prior to the effective date of the change and protected health information it *may* receive in the future. If the Plan materially changes any of its privacy practices that are covered by this Notice, it will revise its Notice and provide you with the revised Notice with the next annual mailing. In addition, copies of the revised Notice will be made available to you upon your written request, and any revised notice will be available at the Plan's website, <https://hr.virginia.edu>.

Protected Health Information

This section describes the administrative procedures used to implement the commitment of the University of Virginia Health Plan and the University of Virginia Dental Plan (collectively referred to in this section as the "Plan") to privacy of protected health information.

Section 1.1 Use and Disclosure of Protected Health Information

The Plan shall use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations. Specifically, the Plan shall use and disclose Protected Health Information for purposes related to healthcare treatment, Payment for healthcare, and Health Care Operations.

- a. "Health Care Operations," as defined by 45 CFR § 164.501, as amended, generally include, but are not limited to, the following activities taken by or on behalf of the Plan:
 1. Quality assessment;
 2. Population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, disease management, or contacting healthcare providers and patients with information about treatment alternatives and related functions;
 3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
 4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to healthcare claims (including stop-loss insurance and excess of loss insurance);
 5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
 6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
 7. Business management and general administrative activities of the Plan, including, but not limited to: management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; customer service, including the provision of data analyses for policyholders, plan sponsors or other customers; resolution of internal grievances; due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity; and any other activity considered to be a "healthcare operation" activity pursuant to 45 CFR § 164.501.

- b. "Payment" activities, as defined by 45 CFR § 164.501, as amended, generally include, but are not limited to, activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom healthcare is provided. These activities include, but are not limited to, the following:
1. Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an Individual's claim);
 2. Coordination of benefits;
 3. Adjudication of health benefit claims (including appeals and other payment disputes);
 4. Subrogation of health benefit claims;
 5. Establishing Eligible Employee contributions;
 6. Risk adjusting amounts due based on an Eligible Employee's health status and demographic characteristics;
 7. Billing, collection activities and related healthcare data processing;
 8. Claims management and related healthcare data processing including auditing payments, investigating and resolving payment disputes, and responding to an Eligible Employee's inquiries about payments;
 9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
 10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
 11. Utilization review, including precertification, preauthorization, concurrent review, and retrospective review;
 12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for Payment purposes: name and address, date of birth, Social Security number, payment history, account number, and name and address of the provider and/or health plan);
 13. Reimbursement to the Plan; and
 14. Any other activity considered to be a "payment" activity pursuant to 45 CFR § 164.501.

Section 1.2 Disclosures by Plan to the Employer

The Plan may:

- a. Disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of: obtaining premium bids from health plans for providing health insurance coverage under the Plan; or modifying, amending, or terminating the Plan. For purposes of this Section, "Summary Health Information" is as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:
1. That summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the Employer has provided health benefits under a group health plan; and
 2. From which the information described at § 164.514(b)(2)(i) of the Privacy Regulations has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five digit zip code.

- b. Disclose to the Employer information on whether an Individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- c. Disclose Protected Health Information to the Employer to carry out Plan administration functions that the Employer performs, consistent with the provisions of Sections 1.5 to 1.7 of this Article.
- d. With an authorization from the Covered Person, disclose Protected Health Information to the Employer for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Employer.
- e. Not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the Employer except as permitted by this Section.
- f. Not disclose (and may not permit a health insurance issuer or HMO to disclose) Protected Health Information to the Employer as otherwise permitted by this Section unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Protected Health Information to the Employer.
- g. Not disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

Section 1.3 Uses and Disclosures by Employer

The Employer may only use and disclose Protected Health Information as permitted and required by the Plan, as set forth within this Article. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The Employer may use and disclose Protected Health Information without an authorization from a Covered Person for Plan administrative functions including Payment activities and Health Care Operations. In addition, the Employer may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Certification described below.

Section 1.4 Certification

The Plan may disclose Protected Health Information to the Employer only upon receipt of a certification from the Employer that the Plan documents have been amended to incorporate the provisions provided for in this Section and that the Employer so agrees to the provisions set forth therein.

Section 1.5 Conditions Agreed to by the Employer

The Employer agrees to:

- a. Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law.
- b. Ensure that any agents, including a subcontractor, to whom UVA provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to UVA with respect to such Protected Health Information, and that such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Health Information belonging to the Plan that is provided by UVA.
- c. Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an Individual.
- d. Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of UVA unless authorized by an Individual.

- e. Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for by this Article, or any Security Incident of which it becomes aware.
- f. Make Protected Health Information available to an Individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524.
- g. Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526.
- h. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
- i. Make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA.
- j. If feasible, return or destroy all Protected Health Information received from the Plan that UVA still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
- k. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.
- l. Ensure that the separation and requirements of Sections 7.09, 7.10, and 7.11 of the Plan are supported by reasonable and appropriate security measures.

Section 1.6 Adequate Separation Between the Plan and UVA

In accordance with HIPAA, only the following employees or classes of employees may be given access to Protected Health Information: UHR Service Team, Financial Analyst, Benefit Program Manager, Wellness Manager, Total Rewards Compliance Manager, Director of Total Rewards, Ombudsman.

Section 1.7 Limitations of Access and Disclosure

The persons described in Section 1.6 of this Article may only have access to and use and disclose Protected Health Information for Plan administration functions that UVA performs for the Plan.

Section 1.8 Noncompliance

If the persons or classes of persons described in Section 1.6 of this Article do not comply with this Plan document, the Plan and UVA shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Section 1.9 Definitions

When the initial letter of a word or phrase is capitalized in this Article, the meaning of such word or phrase shall be as follows:

- a. "Electronic Protected Health Information" or "EPHI" means "electronic protected health information" as defined at 45 CFR § 160.103; which, generally, means Protected Health Information that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means:
 - (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
 - (ii) transmission media used to exchange information already in electronic storage media (e.g., the internet, extranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media).

- b. "Privacy Regulations" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).
- c. "Protected Health Information" means "protected health information," as defined at 45 CFR § 160.103, which generally means information (including demographic information) that (i) identifies an Individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an Individual), (ii) is created or received by a healthcare provider, a health plan, or a healthcare clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of healthcare to an Individual; or the past, present, or future Payment for the provision of healthcare to an Individual. For purposes of this Plan, Protected Health Information shall only include information related to a Benefit Feature: (1) that provides medical care benefits (including medical, dental, vision, long term care, or other coverage affecting any structure of the body) that is subject to the Privacy Regulations; and (2) that is either uninsured or insured and provides Protected Health Information to the Company or UVA.
- d. "Security Incident" means "security incident" as defined at 45 CFR § 164.304; which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- e. "Security Regulations" mean the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, as amended).

Defined Terms

Allowed Amount

The maximum payment the Plan will pay for a covered healthcare service.

Appeal

A request that Aetna review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

When a provider bills you for the balance remaining on the bill that the Plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Behavioral Health Provider

A licensed organization or professional providing diagnostic, therapeutic or psychological services for the treatment of mental health and substance abuse. Behavioral health providers include hospitals, residential treatment facilities, psychiatric physicians, psychologists and social workers.

Brand-Name Drug

A prescription drug that is protected by trademark registration.

Cellular

Relating to or consisting of living cells.

Coinsurance

Once you meet your deductible, the Plan begins paying benefits for covered expenses. The portion paid by the Plan is the Plan's coinsurance. When the Plan's coinsurance is less than 100%, you pay the balance. The percentage of covered expenses that you pay is your coinsurance.

Each Plan option's coinsurance levels are described in the Schedule of Benefits (see "[Your UVA Medical Coverage Options](#)" on page 28).

Companion

This is a person who needs to be with an NME patient to enable him or her:

- To receive services in connection with an NME (National Medical Excellence) procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.

Copay/Copayment

A fixed amount (for example, \$15) you pay at the time you receive a covered healthcare service. The amount can vary by the type of covered healthcare service. A copay applies toward your out-of-pocket maximum.

In the case of a prescription drug, a copay is the fixed amount charged to you at the time a Tier 1 prescription drug is dispensed. The copay is made directly to the pharmacy for each prescription or refill at the time the prescription or refill is dispensed.

Cost Sharing

Your share of the costs for services that the Plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay or the cost of care the Plan does not cover usually are not considered cost sharing.

Custodial Care

This means services and supplies, including room and board and other institutional care, provided to help you in the activities of daily life. You do not have to be disabled. Such services and supplies are custodial care no matter who prescribes, recommends or performs them.

Deductible

The deductible is the part of covered expenses you pay each calendar year before the Plan starts to pay benefits. Amounts above the recognized charge do not count toward your annual deductible.

There are two types of calendar-year deductibles for those enrolled in Choice Health and Value Health:

- *Individual:* The individual deductible applies separately to each covered person in the family. When a person's deductible expenses reach the individual deductible shown in the Schedule of Benefits (see "[Your UVA Medical Coverage Options](#)" on page 28), the person's deductible is met. The Plan then starts to pay benefits for that person at the appropriate coinsurance percentage.
- *Family:* The family deductible applies to the family as a group. When the combined deductible expenses of all covered family members reach the family deductible shown in the Schedule of Benefits (see "[Your UVA Medical Coverage Options](#)" on page 28), the family deductible is met. The Plan then begins to pay benefits for all covered family members.

There are two types of calendar year deductibles for those enrolled in Basic Health:

- *Employee Only*: The employee only deductible applies only to the employee enrolled in employee only coverage. When the employee's deductible expenses reach the employee only deductible shown in the Schedule of Benefits (see "[Your UVA Medical Coverage Options](#)" on page 28), the employee's deductible is met. The Plan then starts to pay benefits for that employee at the appropriate coinsurance percentage.
- *Employee+spouse, Employee+children, and Family*: The employee+spouse (E+Sp), employee+children (E+Ch), and family deductible applies to the enrolled family members as a group. When the combined deductible expenses of all covered family members reach the E+Sp, E+Ch, and family deductible shown in the Schedule of Benefits (see "[Your UVA Medical Coverage Options](#)" on page 28), the E+Sp, E+Ch, and family deductible is met. The Plan then begins to pay benefits for all covered family members.

Dentist

This means a legally qualified dentist or a physician licensed to do the dental work he or she performs.

Detox/Detoxification

This is care mainly to overcome the aftereffects of a specific episode of drinking or substance abuse.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a healthcare provider for everyday or extended use. DME may include oxygen equipment, wheelchairs and crutches.

Emergency Admission

This means a hospital admission when the physician admits you to the hospital right after the sudden and, at that time, unexpected onset of a change in your physical or mental condition that requires confinement right away as a full-time inpatient and for which, if immediate inpatient care were not given, could (as determined by Aetna), reasonably be expected to result in:

- Placing your health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Care

This means the treatment given to you in a hospital's emergency room to evaluate and treat medical conditions of recent onset and severity – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Medical Condition

An illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you did not get medical attention right away. If you did not get immediate medical attention you could reasonably expect one of the following:

- Your health would be put in serious danger;
- You would have serious problems with your bodily functions; or
- You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land or sea. The Plan may not cover all types of emergency medical transportation or may pay less for certain types.

Emergency Room Care/Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services the Plan does not pay for or cover.

Experimental or Investigational (Medical)

A drug, device, procedure or care is considered experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- It does not have the approval required for marketing by the U.S. Food and Drug Administration; or
- A nationally recognized medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and U.S. Department of Health and Human Services; or
- The written protocol(s) or written informed consent used by the treating facility — or another facility studying the same drug, device, treatment or procedure — states that it is experimental, investigational or for research purposes.

Where Can I Find More Information?

Examples of how this evidence is applied to specific treatments and conditions, called Clinical Policy Bulletins, can be found on Aetna's website at www.aetna.com.

Formulary

A list of drugs that the Plan covers. A formulary may include how much your share of the cost is for each drug. The Plan puts drugs in different cost sharing levels or tiers. For example, the Plan's formulary includes generic drug and brand name drug tiers and different cost sharing amounts apply to each tier.

GCIT

Any services that are:

- Gene-based; and
- Cellular and innovative therapeutics.

Gene

A unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Generic Drug

A generic drug is a prescription drug that is not protected by trademark registration but is produced and sold under the chemical formulation name.

Grievance

A complaint that you communicate to Aetna or the Plan.

Health Insurance

A contract that requires a health insurer to pay some or all of your healthcare costs in exchange for a premium. A health insurance contract may also be called a “policy” or “plan”.

Home Health Care

Health care services and supplies you get in your home under your doctor’s orders. Services may be provided by nurses, therapists, social workers or other licensed healthcare providers. Home healthcare usually doesn’t include help with non-medical tasks, such as cooking, cleaning or driving.

Home Health Care Agency

This is an agency that:

- Provides mainly skilled nursing and other therapeutic services; and
- Is associated with a professional group (of at least one physician and one RN) that makes policy; and
- Has full-time supervision by a physician or an RN; and
- Keeps complete medical records for each patient; and
- Has an administrator; and
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for care and treatment in your home. It must be:

- Prescribed in writing by the attending physician; and
- An alternative to inpatient hospital or skilled nursing facility care.

Hospice Care

This is care provided to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency

This is an agency or organization that has hospice care available 24 hours a day and meets any licensing or certification standards established by the jurisdiction where it is located and provides skilled nursing, medical services, social services or psychological and dietary counseling.

- The hospice care agency provides, or arranges for, other services that include:
 - Physician services;
 - Physical and occupational therapy;
 - Part-time home health aide services that consist mainly of caring for terminally ill people; and
 - Inpatient care in a facility when needed for pain control and acute chronic symptom management.
- Has at least the following personnel:
 - One physician;
 - One RN; and
 - One licensed or certified social worker employed by the agency;
- Establishes policies about how hospice care is provided;
- Assesses the patient's medical and social needs;
- Develops a hospice care program to meet those needs;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record for each patient;
- Uses volunteers trained in providing services for non-medical needs; and
- Has a full-time administrator.

Hospice Care Program

This is a written plan of hospice care that:

- Is established by and reviewed from time to time by your attending physician and appropriate hospice care agency personnel;
- Is designed to provide palliative (pain relief) and supportive care to terminally ill people and supportive care to their families; and
- Includes an assessment of your medical and social needs, and a description of the care to be given to meet those needs.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons;
- Is supervised by a staff of physicians;
- Provides 24-hour-a-day RN service;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home; and
- Charges for its services.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. The Plan may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Infertile or Infertility

A person is considered infertile if he or she is unable to conceive or produce conception after one year (6 months if the female partner is over age 35) of frequent, unprotected heterosexual sexual intercourse.

In-Network Care

This is a healthcare service or supply furnished by:

- An in-network provider; or
- A healthcare provider who is not an in-network provider when there is an emergency condition and travel to a provider in the network is not possible.

In-Network Coinsurance

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-Network Provider

This is a healthcare provider who has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna's consent, included in the directory as a preferred care provider for:

- The service or supply involved; and
- The class of employees to which you belong.

LPN

This means a licensed practical nurse.

Mail Order Pharmacy

An establishment where prescription drugs are legally dispensed by mail.

Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis. Treatment for mental disorders is usually provided by or under the direction of a behavioral health provider such as a psychiatrist, psychologist or psychiatric social worker. Mental disorders include (but are not limited to):

- Alcohol and substance abuse
- Anorexia / Bulimia Nervosa
- Schizophrenia
- Schizo-affective disorder
- Bipolar disorder
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

For the purposes of benefits under this Plan, mental disorder will include alcohol and substance abuse only if there is no separate benefit for the treatment of alcohol and substance abuse. Also included is any other mental condition which requires medically necessary treatment.

Molecular

Relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Morbid Obesity

This means your body mass index (BMI) exceeds 40 or your BMI exceeds 35 and you have one of the following conditions:

- Coronary heart disease;
- Type 2 diabetes mellitus;
- Clinically significant obstructive sleep apnea; or
- Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Body mass index (BMI) is a marker that is used to assess the degree of obesity. To calculate your BMI:

- Multiply your weight in pounds by 703.
- Divide the result by your height in inches.
- Divide that result by your height in inches again.

NME Patient

This is a person who:

- Needs any of the National Medical Excellence (NME) program procedure and treatment types covered by the Plan; and
- Contacts Aetna and is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a hospital that Aetna determines is the most appropriate facility.

Necessary/Medically Necessary

The Plan only pays for medically necessary services and supplies.

Health care or dental services and supplies that a physician, other healthcare provider including a behavioral health provider or dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The service or supply must be:

- Provided in accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration;
- Considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, dentist or other healthcare provider; and
- Not more costly than an alternative service or sequence of services that would be at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- For treatment of alcohol or substance abuse that is a program of alcohol or substance abuse therapy and prescribed by a behavior health provider that includes either a follow-up therapy program directed by a physician on at least a monthly basis, or meetings at least once a month with organizations devoted to treatment of alcohol or substance abuse.
- For treatment of a mental disorder for a program that includes a written treatment plan that is prescribed and supervised by a behavior health provider including follow-up treatment and is for a disorder that can be changed for the better.

For these purposes, “generally accepted standards of medical or dental practice” means standards that are:

- Based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community; or
- Otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Negotiated Charge

This is the maximum fee an in-network provider has agreed to charge for any service or supply for the purpose of benefits under this Plan.

Network

The facilities, providers and suppliers the Plan has contracted with to provide healthcare services.

Network Provider (Preferred Provider)

A provider who has a contract with the Plan who has agreed to provide services to members. You will pay less if you see a provider in the network. Also called “preferred provider” or “participating provider”.

Non-Occupational Coverage

The Plan covers only expenses related to non-occupational injury and non-occupational disease.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be considered non-occupational regardless of its cause if proof is provided that you:

- Are covered under any type of Workers' Compensation law; and
- Are not covered for that disease under such law.

Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Non-Preferred Pharmacy

A pharmacy that does not contract with Catalyst Rx to dispense drugs to persons covered under this Plan.

Non-Urgent Admission

An admission which is not an emergency admission or an urgent admission.

Orthodontic Treatment

This is any medical or dental service or supply given to prevent, diagnose or correct a misalignment of:

- The teeth;
- The bite;
- The jaws or jaw joint relationship; or
- Whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Orthotics and Prosthetics

Leg, arm, back and neck braces; artificial legs, arms and eyes; and external breast prostheses after a mastectomy. These services include adjustment, repairs and replacements required because of breakage, wear, loss, or a change in the patient's condition.

Out-of-Network Care

This is a healthcare service or supply provided by an out-of-network provider if, as determined by Aetna:

- The service or supply could have been provided by an in-network provider; and
- The provider does not belong to one or more of the provider categories in the directory.

Out-of-Network Provider (Non-Preferred Provider)

A provider who does not have a contract with the Plan to provide services. If the Plan covers out-of-network services, you will usually pay more to see an out-of-network provider than an in-network or preferred provider. See "[Your UVA Medical Coverage Options](#)" on page 28 for your out-of-network cost share. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-Pocket Maximum

The Plan puts a limit on the amount you pay for covered expenses out of your pocket each year, called the out-of-pocket maximum.

There are two types of out-of-pocket maximums under the Plan:

- *Individual:* The individual out-of-pocket maximum applies separately to each covered person in the family. Once a family member reaches the individual out-of-pocket maximum shown in the Schedule of Benefits (see “[Your UVA Medical Coverage Options](#)” on page 28), the Plan pays 100% of that person’s covered medical expenses for the rest of the calendar year.
- *Family:* The family out-of-pocket maximum applies to you and your dependents as a group. When your family member’s combined out-of-pocket expenses satisfy the family out-of-pocket maximum, the Plan pays 100% of the family’s covered medical charges for the remainder of the calendar year.

Certain expenses do **not** apply toward the out-of-pocket maximum:

- Expenses over the recognized charge;
- Charges for services and supplies that are not covered by the Plan;
- Both the brand name prescription cost sharing and the difference in the cost between the brand name drug and the generic drug when a generic equivalent exists for a brand name drug and the enrollee selects the brand name drug.

Partial Confinement Treatment

A medically supervised day, evening and/or night treatment program for mental health or substance abuse disorders. Care is coordinated by a multidisciplinary treatment team. Services are provided on an outpatient basis for at least four hours per day and are available at least three days per week. The services are of the same intensity and level as inpatient services for the treatment of behavioral health disorders.

Pharmacy

An establishment where prescription drugs are legally dispensed.

Physician

This means a legally qualified physician. The term “doctor” is also used throughout this book and has the same meaning as “physician.”

Plan

Health coverage issues to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain healthcare costs. Also called “health insurance plan”, “policy”, “health insurance policy” or “health insurance”.

Preauthorization

A decision by your health insurance or Plan that a healthcare service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called “prior authorization”, “prior approval” or “precertification”. The Plan requires preauthorization for certain services before you can receive them, except in an emergency. Preauthorization is not a promise the Plan will cover the cost.

Preferred Pharmacy

A pharmacy, including a mail-order pharmacy, that has a contract with Catalyst Rx to dispense drugs to persons covered under this Plan, but only while:

- The contract remains in effect; and
- The pharmacy dispenses prescription drugs under the terms of its contract with Catalyst Rx.

Premium

The amount that must be paid for your Plan. You pay it through payroll contributions or monthly premiums.

Prescriber

Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

Prescription

A prescriber's order for a prescription drug. If it is an oral order (such as a phoned-in prescription), it must be put in writing promptly by the pharmacy.

Prescription Drugs

Drugs and medications that by law require a prescription.

Prescription Drug Coverage

Coverage under the Plan to help pay for prescription drugs. Prescription drugs are grouped together by type or cost. The amount you will pay in cost sharing is different for each "tier" of covered prescription drug.

Preventive Care (Preventive Service)

Routine healthcare, including screenings, check-ups and patient counseling to prevent or discover illness, disease or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of healthcare services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the Plan, who provides, coordinates or helps you access a range of healthcare services.

Provider

An individual or facility that provides healthcare services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility and rehabilitation center. The Plan may require the provider to be licensed, certified or accredited as required by state law.

Psychiatric Hospital

An institution that meets *all* of the following criteria:

- Mainly provides a program for the diagnosis, evaluation and treatment of mental disorders or alcohol or substance abuse.
- Is not mainly a school or custodial, recreational or training institution.
- Provides infirmary-level medical services.
- Provides, or arranges with a hospital in the area to provide, any other medical service that may be needed.
- Is supervised full-time by a psychiatric physician who is responsible for patient care.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides at all times, skilled nursing services by licensed nurses who are supervised by a full-time RN.
- Prepares and maintains a written plan of treatment for each patient. The plan must be supervised by a psychiatric physician.

- Charges for its services.
- Meets licensing standards.

RN

This means a registered nurse.

Recognized Charge

The Plan pays out-of-network benefits only for the allowable part of a covered expense that is recognized. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider's full charge.

Your plan's recognized charge applies to all out-of-network covered expenses except out of network emergency services. It applies even to charges from an out-of-network provider in a hospital that is a network provider. It also applies when your PCP or other network provider refers you to an out-of-network provider. Except for the Aetna facility fee schedule, the recognized charge is determined based on the Geographic area where you receive the service or supply.

The recognized charge is the lower of:

- The provider's usual charge to provide that service or supply; or
- The charge Aetna determines to be appropriate; or
- For non-facility charges (includes professional services and for other services or supplies): 75% of the Reasonable Amount Rate.
- For facility charges: 140% of the Medicare Resource Based Relative Value Scale (RBRVS).

If your ID card displays the National Advantage Program (NAP) logo, your cost may be lower when you get care from a NAP provider. NAP providers are out-of-network providers and third-party vendors that have contracts with Aetna but are not network providers.

Aetna reserves the right to apply their reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided; and
- The educational level, licensure or length of training of the provider

Aetna reimbursement policies are based on the review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice; and
- The views of physicians and dentists practicing in the relevant clinical areas.

Aetna uses commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Aetna facility fee schedule, geographic area, reasonable amount rate, and Medicare allowable rates are defined as follows:

- **Aetna facility fee schedule:** The schedule of rates we developed using our data or experience for out-of-network facility services and supplies. Aetna adjusts the schedule from time to time at their discretion.
- **Geographic area:** The Geographic area is made up of the first three digits of the U.S. Postal Service zip codes. If Aetna determines more data is needed for a particular service or supply, rates may be based on a wider Geographic area such as an entire state.
- **Reasonable amount rate:** There is not a single “reasonable” amount. Your plan establishes the “reasonable” amounts as follows:
 - For professional services and for other services or supplies not mentioned below; and
 - The 75th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates their systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, Aetna reserves the right to substitute a different database that Aetna believes is comparable. If the alternative data source does not contain a value for a particular service or supply, Aetna will base the recognized charge on the Medicare allowable rate.
- **Medicare allowable rates:** Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. Aetna updates their systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, Aetna will determine the rate as follows:
 - Use the same method CMS uses to set Medicare rates;
 - Look at what other providers charge;
 - Look at how much work it takes to perform a service;
 - Look at other things as needed to decide what rate is reasonable for a particular service or supply; or
 - For services of hospitals and other facilities: 140% of the Medicare allowable rate.

Additional Information

Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Member Website to help decide whether to get care in network or out-of-network. Aetna’s secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Member Website to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Cost Estimator” tools.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defect, accident, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-therapy pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Residential Treatment Facility (for alcohol or substance abuse)

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Is admitted by a Physician;
- Has access to necessary medical services 24 hours per day/7 days a week
- If the member requires detoxification services, must have the availability of on- site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs;
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy;
- Has peer-oriented activities;
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director);
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located;
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting;
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally;
- 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation; and

- On-site, licensed Behavioral Health Provider, medical or substance abuse professionals 24 hours per day/7 days a week.

Residential Treatment Facility (for a mental disorder)

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Is admitted by a Physician;
- Has access to necessary medical services 24 hours per day/7 days a week;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs;
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy;
- Has peer-oriented activities;
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director);
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Room and Board Charges

Charges made by an institution for room and board and other necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

If a hospital or other healthcare facility doesn't identify the specific amounts charged for room and board charges and other charges, Aetna will assume that 40% of the total is the room and board charge, and 60% is other charges.

Screening

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs or prevailing medical history of a disease or condition.

Semi-Private Room Rate

This is the room and board charge that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Sharing the Cost of Care

You share in the cost of your medical care by paying deductibles, copays and coinsurance. Refer to the Schedule of Benefits (see “[Your UVA Medical Coverage Options](#)” on page 28), for the specific cost sharing features that apply to each Plan option.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as “skilled care services” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Skilled Nursing Facility

This is an institution that:

- Is licensed or approved under state or local law;
- Qualifies as a skilled nursing facility under Medicare, or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of Hospitals of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities.
- Is primarily engaged in providing skilled nursing care and related services for residents who need:
 - Medical or nursing care; or
 - Rehabilitation services because of injury, illness or disability;
- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
 - Professional nursing care by an RN, or by an LPN directed by a full-time RN; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities;
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time RN;
- Is supervised full-time by a physician or RN;
- Keeps a complete medical record for each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for people who are mentally retarded, or for custodial or educational care;
- Is not mainly a place for the care and treatment of alcoholism, substance abuse or mental disorders, and
- Charges for its services.

A skilled nursing facility may be a rehabilitation hospital or a portion of a hospital designated for skilled or rehabilitation services.

Specialist

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Drug

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

Surgery Center

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards;
- Is set up, equipped, and run to provide general surgery;
- Charges for its services;
- Is directed by a staff of physicians, at least one of whom is on the premises when surgery is performed and during the recovery period;
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed, and during the recovery period;
- Extends surgical staff privileges to physicians who practice surgery in an area hospital and to dentists who perform oral surgery;
- Has at least two operating rooms and one recovery room;
- Provides or arranges with a medical facility in the area for diagnostic X- ray and laboratory services needed in connection with surgery;
- Does not have a place for patients to stay overnight;
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an RN;
- Is equipped and has staff trained to handle medical emergencies;
- Must have a physician trained in CPR, a defibrillator, a tracheotomy set and a blood volume expander;
- Has a written agreement with an area hospital for the immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them;
- Provides an ongoing quality assurance program that includes reviews by physicians who do not own or direct the facility; and
- Keeps a medical record for each patient.

Telemedicine

A telephone or internet-based consult with a provider that has contracted with Aetna to offer these services.

Terminally Ill

This is a medical prognosis of 12 months or fewer to live.

Therapeutic

A treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

Urgent Admission

An urgent admission is one where the physician admits you to the hospital because of:

- The onset of, or change in, a disease; or
- The diagnosis of a disease; or
- An injury caused by an accident; that, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for confinement becomes apparent.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Urgent Care Provider

This is a freestanding medical facility that:

- Provides unscheduled medical services to treat an urgent condition if your physician is not reasonably available;
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours;
- Charges for services;
- Is licensed and certified as required by state or federal law or regulation;
- Keeps a medical record for each patient;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or run the facility;
- Is run by a staff of physicians, with one physician on call at all times; and
- Has a full-time administrator who is also a physician.

An urgent care provider may also be a physician's office if it has contracted with Aetna to provide urgent care and is, with Aetna's consent, included in its provider directory as an in-network urgent care provider.

A hospital emergency room or outpatient department is not considered to be an urgent care provider.

Urgent Condition

This is a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious health problems;
- Includes a condition that could cause you severe pain that cannot be managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency room; and
- Requires immediate outpatient medical care that can't be postponed until your physician becomes reasonably available.

Walk-In Clinic

A free-standing healthcare facility that has contracted with Aetna to:

- Treat unscheduled and/or non-emergency illnesses and injuries; and
- Administer certain immunizations.

A walk-in clinic must:

- Provide unscheduled and/or non-emergency medical services;
- Make charges for the services provided;
- Be licensed and certified as required by any state or federal law or regulation;
- Be staffed by independent practitioners, such as Nurse Practitioners, licensed in the state where the clinic is located;
- Keep a medical record on each patient;
- Provide an ongoing quality assurance program;
- Have at least one physician on call at all times;
- Have a physician who sets protocol for clinical policies, guidelines and decisions; and
- Not be the emergency room or outpatient department of a hospital.

Summaries of Benefits and Coverage



THE UNIVERSITY OF VIRGINIA HEALTH PLAN: Integrated Delivery System Open Choice® -

Value Health

Coverage for: Individual + Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	UVA Provider <u>Network</u> : Individual \$800 / Family \$1,600. Aetna <u>Network</u> : Individual \$800 / Family \$1,600. Out-of-Network: Individual \$1,600 / Family \$3,200.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	UVA Provider <u>Network</u> : Individual \$5,500 / Family \$11,000. Aetna <u>Network</u> : Individual \$5,500/Family \$11,000. Out-of-Network: Individual \$11,000/Family \$22,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of Home Host <u>providers</u> .	You pay the least if you use a <u>provider</u> in designated <u>network</u> . You pay more if you use a <u>provider</u> in Non-Designated <u>Network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	\$80 <u>copay</u> /visit	40% <u>coinsurance</u>	Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year
	<u>Preventive care / screening / immunization</u>	No charge, except hearing exams not covered	No charge, except hearing exams not covered	Not covered	Age and frequency schedules may apply
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by Optum Rx</p> <p>More information about prescription drug coverage is available at www.catalystx.com</p>	Tier 1 drugs (most generics and potentially some cost-effective branded medications)	\$6 copay/30 days	\$6 copay/30 days; \$14 copay/90 days mail order	\$6 copay plus billed amount minus contracted rate/30 days	<p>Covers up to 30-day supply; 90-day supply (mail order prescription) from OptumRx Home Delivery only. No Charge for formulary generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generic.</p>
	Tier 2 drugs (most brand name drugs and most costly or less desirable generics)	After deductible , 20% coinsurance with \$150 max/30 days	After deductible , 20% coinsurance with \$34 min/\$150 max 30 days, 15% coinsurance with \$75 min/\$375 max 90 days mail order	After deductible , 20% coinsurance with \$34 min/\$150 max plus billed amount minus contracted rate/30 days	
	Tier 3 drugs (non-preferred brand drugs and more costly or less desirable generics)	After deductible , 20% coinsurance with \$225 maximum/RX 30 days	After deductible , 20% coinsurance with \$68 min/\$225 max 30 days, 15% coinsurance with \$150 min/\$475 max 90 days mail order	After deductible , 20% coinsurance with \$68 min/\$225 max plus billed amount minus contracted rate/30 days	
	<u>Specialty drugs</u> : Tier 1, Tier 2, Tier 3	1: 20% coinsurance to \$100 max; 2: 20% coinsurance with \$150 max; 3: 20% coinsurance with \$200 max	Not covered	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	No coverage for non-emergency use.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency transport.
	Urgent care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay/visit</u> , other outpatient services: 20% <u>coinsurance</u>	Office: \$40 <u>copay/visit</u> , other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	40% <u>coinsurance</u>	Cost sharing doesn't apply to certain preventive services .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization for out-of-network care may apply.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	\$40 copay/visit	\$40 copay/visit	40% <u>coinsurance</u>	Coverage is limited to 40 visits per calendar year for Physical and Occupational Therapy combined, 40 visits per calendar year for Speech Therapy.
	Habilitation services	\$40 copay/visit	\$40 copay/visit	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for <u>out-of-network</u> care.
If your child needs dental or eye care	Children's eye exam	Not applicable	Not covered	Not covered	Not covered
	Children's glasses	Not applicable	Not covered	Not covered	Not covered
	Children's dental check-up	Not applicable	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs – Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture – 20 visits/calendar year
- Bariatric surgery
- Chiropractic care – 26 visits/calendar year
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Artificial insemination, ovulation induction & advanced reproductive technology: \$15,000 maximum/lifetime.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a plan through the **Marketplace**.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on **the cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's overall deductible** **\$800**
- **Specialist copayment** **\$50**
- **Hospital (facility)coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$74
Coinsurance	\$2,001
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,935

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** **\$800**
- **Specialist copayment** **\$50**
- **Hospital (facility)coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
<i>Cost Sharing</i>	
Deductibles*	\$900
Copayments	\$426
Coinsurance	\$1,089
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Peg would pay is	\$2,470

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's overall deductible** **\$800**
- **Specialist copayment** **\$50**
- **Hospital (facility)coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$280
Coinsurance	\$311
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,391

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

*Note: This **plan** has other **deductibles** for specific services included in this coverage example. See "Are there other **deductibles** for specific services?" row above

The **plan** would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For each calendar year, <u>Network</u> : Individual \$800 / Family \$1,600. Out-of- <u>Network</u> : Individual \$1,600 / Family \$3,200.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. Preventive care is covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : Individual \$5,500 / Family \$11,000. Out-of- <u>Network</u> : Individual \$11,000 / Family \$22,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of network <u>providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year
	<u>Preventive care / screening / immunization</u>	No charge, except hearing exams not covered	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your plan will pay for
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by Optum Rx</p> <p>More information about prescription drug coverage is available at www.catalystrx.com</p>	Tier 1 drugs (most generics and potentially some cost-effective branded medications)	\$6 copay/30 days	\$6 copay/30 days; \$14 copay/90 days mail order	\$6 copay plus billed amount minus contracted rate/30 days	Covers up to 30-day supply; 90-day supply (mail order prescription) from OptumRx Home Delivery only. No Charge for formulary generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generic.
	Tier 2 drugs (most brand name drugs and most costly or less desirable generics)	After deductible , 20% coinsurance with \$150 max/30 days	After deductible , 20% coinsurance with \$34 min/\$150 max 30 days, 15% coinsurance with \$75 min/\$375 max 90 days mail order	After deductible , 20% coinsurance with \$34 min/\$150 max plus billed amount minus contracted rate/30 days	
	Tier 3 drugs (non-preferred brand drugs and more costly or less desirable generics)	After deductible , 20% coinsurance with \$225 maximum/RX 30 days	After deductible , 20% coinsurance with \$68 min/\$225 max 30 days, 15% coinsurance with \$150 min/\$475 max 90 days mail order	After deductible , 20% coinsurance with \$68 min/\$225 max plus billed amount minus contracted rate/30 days	
	<u>Specialty drugs</u> : Tier 1, Tier 2, Tier 3	1: 20% coinsurance to \$100 max; 2: 20% coinsurance with \$150 max; 3: 20% coinsurance with \$200 max	Not covered	Not covered	Covers up to 30-day supply. <u>Specialty drugs</u> must be filled through UVA Specialty Pharmacy. Mandatory generics required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	25% <u>coinsurance</u>	25% <u>coinsurance</u>	No coverage for non-emergency use.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency transport.
	Urgent care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay</u> /visit; Other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge for routine services	40% <u>coinsurance</u>	Cost sharing doesn't apply to certain preventive services . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	\$40 copay/visit	40% <u>coinsurance</u>	Limited to 40 visits/calendar year for Physical and Occupational Therapy combined, 40 visits/calendar year for Speech Therapy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage limited to 180 days/calendar year. Pre-authorization required for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not applicable	Not covered	Not covered
	Children's glasses	Not applicable	Not covered	Not covered
	Children's dental check-up	Not applicable	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs – Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture – 20 visits/calendar year
- Bariatric surgery
- Chiropractic care – 26 visits/calendar year
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Artificial insemination, ovulation induction & advanced reproductive technology: \$15,000 maximum/lifetime.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's overall deductible** \$800
- **Specialist copayment** \$50
- **Hospital (facility)coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$74
Coinsurance	\$2,001
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,935

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** \$800
- **Specialist copayment** \$50
- **Hospital (facility)coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
<i>Cost Sharing</i>	
Deductibles*	\$900
Copayments	\$426
Coinsurance	\$1,089
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Peg would pay is	\$2,470

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's overall deductible** \$800
- **Specialist copayment** \$50
- **Hospital (facility)coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$280
Coinsurance	\$311
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,391

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.



ChoiceHealth

Coverage for: Individual + Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	UVA Provider <u>Network</u> : Individual \$500 / Family \$1000. Aetna <u>Network</u> : Individual \$500 / Family \$1000. Out-of-Network: Individual \$1,500 / Family \$3,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care is covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	UVA Provider <u>Network</u> : Individual \$5,500 / Family \$11,000. Aetna <u>Network</u> : Individual \$5,500/Family \$11,000. Out-of-Network: Individual \$11,000/Family \$22,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of Home Host <u>providers</u> .	You pay the least if you use a <u>provider</u> in the UVA provider <u>network</u> . You pay more if you use a <u>provider</u> in the Aetna <u>Network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	<u>Specialist</u> visit	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge, except hearing exams not covered	No charge, except hearing exams not covered	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your plan will pay for. Age and frequency schedules apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by Optum Rx</p> <p>More information about prescription drug coverage is available at www.mycatamaranrx.com</p>	Tier 1 drugs (most generics and potentially some cost-effective branded medications)	\$6 copay/30 days	\$6 copay/30 days; \$14 copay/90 days mail order	\$6 copay plus billed amount minus contracted rate/30 days	<p>Covers up to 30-day supply; 90-day supply (mail order prescription) from OptumRx Home Delivery only.</p> <p>No Charge for formulary generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generic.</p>
	Tier 2 drugs (most brand name drugs and more costly or less desirable generics)	After deductible: 20% coinsurance with \$150 max/30 days	After deductible: 20% coinsurance with \$34 min/\$150 max 30 days; 15% <u>coinsurance</u> with \$75 min/\$375 max 90 days mail order	After <u>deductible</u> : 20% coinsurance with \$34 min/\$150 max plus billed amount minus contracted rate/30 days	
	Tier 3 drugs (non-preferred brand drugs and more costly or less desirable generics)	After <u>deductible</u> , 20% <u>coinsurance</u> with \$225 maximum/30 days	After deductible, 20% <u>coinsurance</u> with \$68 min/\$225 max 30 days, 15% coinsurance with \$150 min/\$475 max 90 days mail order	After deductible, 20% <u>coinsurance</u> with \$68 min/\$225 max plus billed amount minus contracted rate/30 days	
	<u>Specialty drugs</u> : Tier 1, Tier 2, Tier 3	1: 20% <u>coinsurance</u> with \$100 max; 2: 20% <u>coinsurance</u> with \$150 max; 3: 20% <u>coinsurance</u> with \$200 max	Not covered	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery)	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency use.
	Emergency medical transportation	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	No coverage for non-emergency transport.
	Urgent care	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office and other outpatient services: 15% <u>coinsurance</u>	Office and other outpatient services: 15% <u>coinsurance</u>	Office and other outpatient services: 35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Inpatient services	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	35% <u>coinsurance</u>	Cost sharing doesn't apply to certain preventive services . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	90 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Coverage is limited to 40 visits per calendar year for Physical and Occupational Therapy combined, 40 visits per calendar year for Speech Therapy
	Habilitation services	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	180 days/calendar year. Pre-authorization required for out-of-network care.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not applicable	Not covered	Not covered	Not covered
	Children's glasses	Not applicable	Not covered	Not covered	Not covered
	Children's dental check-up	Not applicable	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child) • Hearing aids 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult & Child) 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs – Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> • Acupuncture – 20 visits/calendar year • Bariatric surgery • Chiropractic care – 26 visits/calendar year 	<ul style="list-style-type: none"> • Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition. • Artificial insemination, ovulation induction & advanced reproductive technology: \$15,000 maximum/lifetime.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby
(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's overall deductible** **\$500**
- **Specialist copayment** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$24
Coinsurance	\$1,260
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,844

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** **\$500**
- **Specialist copayment** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$186
Coinsurance	\$1,009
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Peg would pay is	\$1,850

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The **plan's overall deductible** **\$500**
- **Specialist copayment** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$193
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$693

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

*Note: This **plan** has other **deductibles** for specific services included in this coverage example. See "Are there other **deductibles** for specific services?" row above

The **plan** would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : EE Only \$2,000; EE+ Family \$4,000. Out-of-Network: EE Only \$6,000; EE+ Family \$12,000	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. In- <u>network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : EE Only \$4,000; EE+Family: \$8,000. Out-of-Network: EE Only \$8,000; EE+Family: \$16,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of network <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Age and frequency schedules may apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by Optum Rx</p> <p>More information about prescription drug coverage is available at www.mycatamaranrx.com</p>	Tier 1 drugs (generic drugs)	20% <u>coinsurance</u>	Member pays full cost of medication then files claim to be reimbursed for all but the applicable coinsurance.	<p>Covers 90 day supply. Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u>. Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Mandatory generic substitution.</p> <p>The plan will factor the Average Wholesale Price (AWP) for the drug into the reimbursement equation when reimbursing members for Out of Network claims. The calculation will be AWP + 10%. The difference between the full cost of what the member paid at the pharmacy and the AWP + 10% calculated amount would be the member's responsibility.</p> <p>Example 1: Pharmacy charges member \$100 for a prescription medication. AWP is \$75 plus 10% (\$7.50) = \$82.50 Member has 20% coinsurance. The plan reimburses member \$72.50 (\$75 + \$7.50 (10% of AWP)) = \$82.50 minus 20% (\$16.50).</p> <p>Covers up to 30-day supply. <u>Specialty drugs</u> must be filled through UVA Specialty Pharmacy. Mandatory generics required.</p>
	Tier 2 drugs (formulary brand-name drugs)	20% <u>coinsurance</u>	Member pays full cost of medication then files claim to be reimbursed for all but the applicable coinsurance.	
	Tier 3 drugs (non-formulary brand-name drugs)	20% <u>coinsurance</u>	Member pays full cost of medication then files claim to be reimbursed for all but the applicable coinsurance.	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

If you need immediate medical attention	Emergency room care	25% <u>coinsurance</u>	25% <u>coinsurance</u>	No coverage for non-emergency use.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% coinsurance for non-emergency transport.
	Urgent care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office and other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	Cost sharing doesn't apply to certain preventive services . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 90 visits/calendar year. Pre-authorization required for out-of-network care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 40 visits per calendar year for Physical and Occupational Therapy combined, 40 visits per calendar year for Speech Therapy, including outpatient hospital services. Includes treatment of Autism & developmental delays.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 180 days/calendar year. Pre-authorization required for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not applicable	Not covered	Not covered
	Children's glasses	Not applicable	Not covered	Not covered
	Children's dental check-up	Not applicable	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child) • Hearing aids 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult & Child) 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs – Except for required preventive services.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture – 20 visits/calendar year • Bariatric surgery • Chiropractic care – 26 visits/calendar year 	<ul style="list-style-type: none"> • Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition. • Artificial insemination, ovulation induction & advanced reproductive technology: \$15,000 maximum/lifetime. 	

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the [plan](#) at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church [plan](#), church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your [plan](#) doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a [plan](#) through the [Marketplace](#).

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's overall deductible** \$2,000
- **Specialist copayment** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
<i>Cost Sharing</i>	
Deductibles*	\$2,000
Copayments	\$0
Coinsurance	\$2,527
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,587

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** \$2,000
- **Specialist copayment** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
<i>Cost Sharing</i>	
Deductibles*	\$2,000
Copayments	\$0
Coinsurance	\$1,437
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Peg would pay is	\$3,492

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's overall deductible** \$2,000
- **Specialist copayment** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
<i>Cost Sharing</i>	
Deductibles*	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,900

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance policy](#). Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

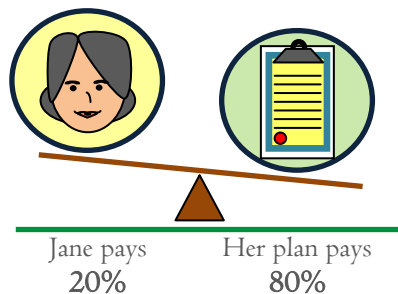
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [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 insurance or [plan](#) pays the rest of the allowed amount.)



Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

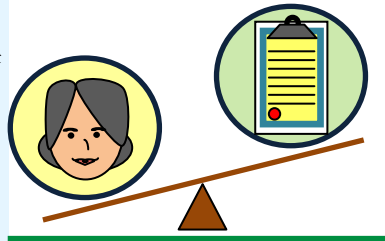
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%
(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the “individual mandate”, the duty you may have to be enrolled in health coverage that provides [minimum essential coverage](#). If you don’t have [minimum essential coverage](#), you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered healthcare services. Your share is usually lower for in-[network](#) covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-[network](#) services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the [individual responsibility requirement](#). Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

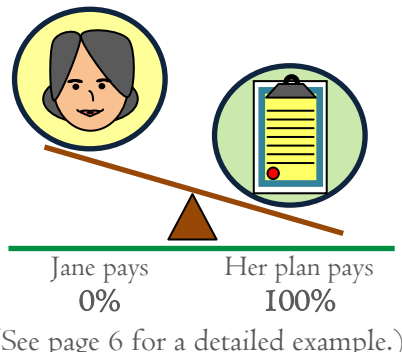
A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

A [provider](#) who doesn't have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you'll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the [plan](#) will usually pay 100% of the



[allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "[health insurance](#)".

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called prior authorization, prior approval or precertification. Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each "tier" of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is *not* the same as “skilled care services”, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

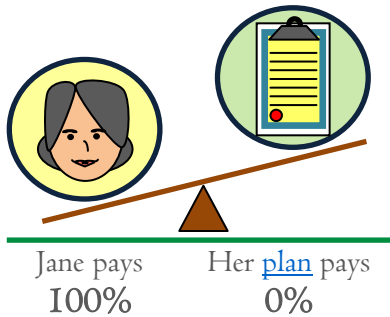
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

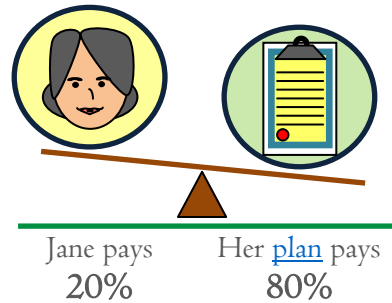
January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



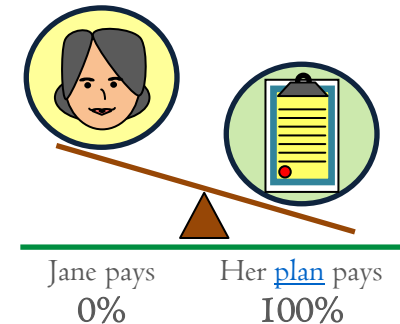
Jane hasn't reached her \$1,500 deductible yet

Her [plan](#) doesn't pay any of the costs.
Office visit costs: \$125
Jane pays: \$125
Her plan pays: \$0



Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her [deductible](#). So her [plan](#) pays some of the costs for her next visit.
Office visit costs: \$125
Jane pays: 20% of \$125 = \$25
Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her [plan](#) pays the full cost of her covered health care services for the rest of the year.
Office visit costs: \$125
Jane pays: \$0
Her plan pays: \$125

