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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 Network: Individual $800 / Family $1,600. Aetna Network: Individual $800 / Family $1,600. Out–of–Network: Individual $1,600 / Family $3,200.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services 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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	UVA Provider Network: Individual $5,500 / Family $11,000. Aetna Network: Individual $5,500/Family $11,000. Out-of-Network: Individual $11,000/Family $22,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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 providers.	You pay the least if you use a provider in designated network. You pay more if you use a provider in Non-Designated Network. You will pay the most if you use an out-of- network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 copay/visit	$40 copay/visit	40% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$50 copay/visit	$80 copay/visit	40% coinsurance	Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year
	Preventive care / screening / immunization	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	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	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 may more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition **Prescription drug coverage** is administered by Optum Rx More information about **prescription drug coverage** is available at www.catalystrx.com	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	
	Specialty drugs: 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. Specialty drugs must be filled through UVA Specialty Pharmacy. Mandatory generics required.
If you have outpatient surgery	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 may more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	25% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	No coverage for non-emergency transport.
	Urgent care	20% coinsurance	20% coinsurance	20% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay/visit, other outpatient services: 20% coinsurance	Office: $40 copay/visit, other outpatient services: 20% coinsurance	Office & other outpatient services: 40% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	40% coinsurance	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% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	90 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	$40 copay/visit	$40 copay/visit	40% coinsurance	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% coinsurance	

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 may more)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	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 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) orwww.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) orwww.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**
Cost Sharing	
Deductibles*	$800
Copayments	$74
Coinsurance	$2,001
What isn't covered	
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**
Cost Sharing	
Deductibles*	$900
Copayments	$426
Coinsurance	$1,089
What isn't covered	
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**
Cost Sharing	
Deductibles*	$800
Copayments	$280
Coinsurance	$311
What isn't covered	
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.