**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**

THE UNIVERSITY OF VIRGINIA HEALTH PLAN: Open Choice® - Choice Health

**Coverage Period:** 01/01/2021-12/31/2021

**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](http://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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-370-4526 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $1,500 / Family $3,000.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network preventive care is covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: Individual $5,500 / Family $11,000. Out-of-Network: Individual $11,000 / Family $22,000.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-987-9072 for a list of UVA Network providers.</td>
<td>You pay the least if you use a provider in the UVA Provider Network. You pay more if you use a provider in the Aetna 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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge, except hearing exams not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$6 copay/30 days; $14 copay/90 days mail order</td>
<td>$6 copay plus billed amount minus contracted rate/30 days</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $34 min/$150 max/30 days, 15% coinsurance with $75 min/$375 max 90 days mail order</td>
<td>After deductible, 20% coinsurance with $34 min/$150 max plus billed amount minus contracted rate/30 days</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $68 min/$225 max/30 days, 15% coinsurance with $150 min/$475 max/90 days mail order</td>
<td>After deductible, 20% coinsurance with $68 min/$225 max plus billed amount minus contracted rate/30 days</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.aetnapharmacy.com/standard](http://www.aetnapharmacy.com/standard)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs: Generic (G), Preferred brand (P), Non-preferred brand (N)</td>
<td>After deductible, G: 20% coinsurance with $100 max; P: 20% coinsurance with $150 max; N: 20% coinsurance with $200 max</td>
<td>Not covered</td>
<td>Covers up to 30-day supply. Specialty drugs must be filled through UVA Specialty Pharmacy. Limited Distribution Specialty Drugs may be filled through CVS Specialty Pharmacy. Mandatory generics required.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 15% coinsurance</td>
<td>Office &amp; other outpatient services: 35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge for routine services</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
</tbody>
</table>

Note: Pre-authorization is required for all out-of-network services.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care:

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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 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 http://www.dol.gov/ebia/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 on how 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 http://www.dol.gov/ebia/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.
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. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
</tr>
<tr>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
</tr>
<tr>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

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: $500
- Copayments: $24
- Coinsurance: $1,260

What isn't covered:
- Limits or exclusions: $60

The total Peg would pay is: **$1,844**

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: $600
- Copayments: $186
- Coinsurance: $1,009

What isn't covered:
- Limits or exclusions: $55

The total Joe would pay is: **$1,850**

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: $500
- Copayments: $0
- Coinsurance: $193

What isn't covered:
- Limits or exclusions: $0

The total Mia would pay is: **$693**

The plan would be responsible for the other costs of these EXAMPLE covered services.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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.

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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.
Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic - እንግዳን ከንወት ሰብዑስ ይህ ከገደም 1-800-370-4526 የሚ የከራከሩ ያልተካ.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian - Ներկա գործիքներից պագետություն (հայերեն) կապից 1-800-370-4526 անցկացնեք քննի.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayaang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - ကိုက်ညီသော အများအားဖြင့် တီထွင်ပြုလုပ်ခြင်း 1-800-370-4526 ကြည့်ပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee - ᏥᏬᎩᏣ ᏭᏫ ᏮᏧᏣᏲᏛᏫ ᏦᏫᏭᏝᏨᏳ (GWW) ᏤᏭᎪ 1-800-370-4526 Ꭻ ᎠᏫ ᎣᏭ ᏥᏫ ᏭᎪ ᏰᎲ Ꮲ ᏨᏳ.
Chinese - 欲取得繁體中文語言協助，請撥打1-800-370-4526，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.
Cushite - Gargaarsa afaan Oromiffa hiikuuf argachuuf lakokokofsaa bilbilaa 1-800-370-4526 irre tilil bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appelez le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં સહાય મળે કોઈ પણ અર્થ વચ્ચે 1-800-370-4526 પર ડિલેલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai’i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
Proprietary
To obtain help from a Russian-speaking translator, call 1-800-370-4526.

To obtain assistance from a Samoan-speaking translator, call 1-800-370-4526.

For assistance in Serbo-Croatian, call 1-800-370-4526.

For Spanish assistance, call 1-800-370-4526.

For assistance in Sudanic-Fulfude, call 1-800-370-4526.

For Swahili assistance, call 1-800-370-4526.

For assistance in Syriac, call 1-800-370-4526.

For assistance in Tagalog, call 1-800-370-4526.

For Telugu assistance, call 1-800-370-4526.

For Thai assistance, call 1-800-370-4526.

For Tongan assistance, call 1-800-370-4526.

For Trukese assistance, call 1-800-370-4526.

For Turkish assistance, call 1-800-370-4526.

For Ukrainian assistance, call 1-800-370-4526.

For assistance in Urdu, call 1-800-370-4526.

For Vietnamese assistance, call 1-800-370-4526.

For assistance in Yiddish, call 1-800-370-4526.

For Yoruba assistance, call 1-800-370-4526.