UNIVERSITY OF VIRGINIA HEALTH PLAN
2019 SCHEDULE OF AETNA NATIONAL NETWORK BENEFITS
COMPARISON OF BASIC HEALTH, VALUE HEALTH, AND CHOICE HEALTH

SERVICES PROVIDED	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
1. PLAN COINSURANCE Applies to all expenses unless otherwise stated.			
	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
2. PROFESSIONAL SERVICES IN OFFICE OR OUTPATIENT			
A. Primary Care Physician Visit	Deductible & 20% Coinsurance	$30 Copayment	Deductible & 10% Coinsurance
B. Specialty Care Visit	Deductible & 20% Coinsurance	$60 Copayment	Deductible & 10% Coinsurance
C. Maternity Visit	Paid in Full[1]	Paid in Full[1]	Paid in Full[1]
3. PREVENTIVE CARE AND IMMUNIZATIONS			
A. Preventive General Physical Examination (PCP Only)	Paid in Full	Paid in Full	Paid in Full
B. Preventive Well Child Care (Under Age 7) (PCP Only)	Paid in Full	Paid in Full	Paid in Full
C. Preventive Diagnostic Tests, Laboratory Services and XRay Procedures (Non-Urgent Only)	Paid in Full[1]	Paid in Full[1]	Paid in Full[1]
D. For Common Communicable Diseases as per CDC Guidelines excluding those used for Foreign Travel	Paid in Full	Paid in Full	Paid in Full
4. URGENT CARE CENTER *(Must be an unexpected illness or injury where services are needed sooner than a routine doctor's visit)*			
	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance

SERVICES PROVIDED	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
5. EMERGENCY ROOM SERVICES Emergency Room Services will be processed under the Hospital Care Benefits if patient is admitted. *(Must be an emergency to receive benefits.)*			
Emergency Room Visit	Deductible & 25% Coinsurance	Deductible & 25% Coinsurance	Deductible & 15% Coinsurance
Other Associated Charges	Deductible & 25% Coinsurance	Deductible & 25% Coinsurance	Deductible & 15% Coinsurance
6. INPATIENT HOSPITAL			
A. Inpatient Care (Semi-Private Accommodations Unless Private Accommodations are Approved for Medical Reasons)	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
B. Limitation on Inpatient Days	Unlimited	Unlimited	Unlimited
7. TRANSPLANT SERVICES Using Institutes of Excellence Network			
Inpatient Services and Other Associated Charges	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
8. OUTPATIENT HOSPITAL			
Outpatient Procedures	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
Other Associated Charges	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
9. SKILLED NURSING FACILITY			
Skilled Nursing / Rehabilitation Facility (180 Days Per Year Combined Maximum)	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
10. HOME HEALTH SERVICES			
Medically Necessary Services Approved By Claims Administrator (90 Visits Per Year Maximum)	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
11. AMBULANCE TRANSPORTATION			
Local Ground or Air Transportation When Medically Necessary To and/or From a Hospital	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance

SERVICES PROVIDED	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
12. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
A. Inpatient Acute Care for Non-Biologically Based Mental Illnesses	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
B. Inpatient Care for Biologically Based Mental Illnesses	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance
C. Outpatient Treatment for Non-Biologically Based Mental Health Illnesses	Deductible & 20% Coinsurance	$30 Copayment	Deductible & 10% Coinsurance
D. Outpatient Treatment for Biologically Based Mental Illnesses	Deductible & 20% Coinsurance	$30 Copayment	Deductible & 10% Coinsurance
13. SPEECH THERAPY			
Medically Necessary Restorative Services, Non-developmental Conditions except under age 5 (40 Visits Per Year Maximum)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 10% Coinsurance
14. PHYSICAL/ OCCUPATIONAL THERAPY			
Medically Necessary Restorative Services, Non-developmental Conditions except Occupational Therapy under age 5 (40 Visits Per Year Combined Maximum)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 10% Coinsurance
15. CHIROPRACTIC CARE			
26 Spinal Manipulations Per Year Maximum	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 10% Coinsurance
16. ACUPUNCTURE			
Medically Necessary Acupuncture Services (20 Visits Per Year Maximum)	Deductible & 20% Coinsurance	$40 Copayment	Deductible & 10% Coinsurance
17. DURABLE MEDICAL EQUIPMENT			
Medically Necessary Equipment, Prosthetic Appliances, and Medical Supplies	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 10% Coinsurance

SERVICES PROVIDED	BASIC HEALTH	VALUE HEALTH*	CHOICE HEALTH
18. PRESCRIPTION DRUGS Using Participating Pharmacies			
Covered drugs are evaluated and selected from OptumRx's Premium Formulary. Covered drugs require a written prescription and approval by FDA. Participating Pharmacy cost-sharing is detailed on this schedule. The Plan mandates Generic Substitution: Coverage is limited to cost of Generic when available. *When a Generic equivalent exists for a Brand Name prescription, the Enrollee 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*[2]. UVA Pharmacy is able to purchase drugs for lower costs than most pharmacies. This results in a reduced cost to participants since the cost-sharing is a % of the cost of the drug.	***Retail Pharmacy Network:*** Deductible & 20% at participating Pharmacies for up to *90-day supply*. ***OptumRx Home Delivery:*** Deductible & 20% for up to *90-day supply through mail order*. Specialty Drugs are available only in a supply *up to 30 days*. Specialty Drugs must be filled through ***UVA Specialty Pharmacy in order to be covered.*** Deductible & 20%. UVA Specialty Pharmacy includes UVA Barringer, Emily Couric Clinical Cancer Center, UVA Bookstore, Zion Crossroads, and UVA Cancer Center August Pharmacies. 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 non-covered drugs does not count towards the deductible or out-of-pocket maximum[2]. Contraceptive drugs and devices are covered. Over-the-counter preventive items mandated by the federal health care reform law are covered with a prescription. Other over-the-counter items are not covered.	***Retail Pharmacy Network:*** $6 (Tier 1), Deductible & 20% with $30 min/$125 max (Tier 2), and Deductible & 20% with $60 min/$175 max (Tier 3) cost sharing per prescription for up to a *30-day supply at Participating Pharmacies* only; $100 annual deductible for Tier 2 and Tier 3 retail drugs. ***When using UVA Pharmacies:*** $6 (Tier 1), Deductible & 20% with $125 max (Tier 2), and Deductible & 20% with $175 max (Tier 3) cost sharing per prescription for up to a *30-day supply;* $100 annual deductible for Tier 2 and Tier 3 retail drugs. UVA Pharmacies include UVA, Emily Couric Clinical Cancer Center, UVA Bookstore, Zion Crossroads, and UVA Cancer Center Augusta Pharmacies. *31- to 90-day supply* may be purchased at *Participating Retail Pharmacies* with no discounted copayment. ***OptumRx Home Delivery:*** $14 (Tier 1), 15% with $60 min/$325 max (Tier 2), and 15% coinsurance with $120 min/$375 max (Tier 3) cost sharing per prescription for up to *90-day supply through mail order*. Specialty Drugs are available only in a supply *up to 30 days*. Specialty Drugs must be filled through ***UVA Specialty Pharmacy in order to be covered:*** 20% with $75 max (Tier 1), 20% with $125 max (Tier 2), and 20% with $175 max (Tier 3) cost sharing per prescription. 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 non-covered drugs does not count towards the deductible or out-of-pocket maximum[2]. Contraceptive drugs and devices are covered. Over-the-counter preventive items mandated by the federal health care reform law are covered with a prescription. Other over-the-counter items are not covered.	
19. CALENDAR YEAR DEDUCTIBLE Deductible is applicable to services and Covered Prescriptions that have Coinsurance; deductible is not applicable to medical services that have Copayments or to Amounts above the Allowable Amount[2].		Deductible is applicable to medical services that have Coinsurance; deductible is not applicable to medical services that have Copayments or to Prescriptions or to Amounts above the Allowable Amount.	
A.	$2,000 for employee only	$1,000 per individual	$400 per individual
B.	$4,000 for E+spouse, E+children, family	$2,000 per family	$800 per family
20. MAXIMUM OUT-OF-POCKET Includes Coinsurance, Deductible, Copayments and covered Prescriptions; Excludes Amounts above Allowable Amount and Penalties[2].			
A. Per Individual	$5,500	$5,500	$5,500
B. Per Family	$11,000	$11,000	$11,000

*Reduced cost-sharing is available for some services when participants enrolled in Value Health use the UVA Provider Network.

[1]All options will pay 100% of in-network preventive diagnostic, laboratory, and xray procedures. The plan coinsurance will be applied for in-network non-preventive diagnostic, laboratory, and xray procedures after the annual deductible has been met.

[2]When a generic equivalent exists for a brand name prescription and the enrollee selects the brand name drug, 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.