UNIVERSITY OF VIRGINIA HEALTH PLAN
2019 SCHEDULE OF BENEFITS
CHOICE HEALTH

SERVICES PROVIDED	IN-NETWORK[1]	OUT-OF-NETWORK[2]
	Direct Access through Aetna network providers	**Care provided by non-participating providers**
1. PLAN COINSURANCE Applies to all expenses unless otherwise stated.		
	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
2. PROFESSIONAL SERVICES IN OFFICE OR OUTPATIENT		
A. Primary Care Physician Visit	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
B. Specialty Care Visit	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
C. Maternity Visit	Paid in Full[3]	Deductible & 35% Coinsurance
3. PREVENTIVE CARE AND IMMUNIZATIONS		
A. Preventive General Physical Examination (PCP Only)	Paid in Full	Available In-Network Only
B. Preventive Well Child Care (Under Age 7) (PCP Only)	Paid in Full	Available In-Network Only
C. Preventive Diagnostic Tests, Laboratory Services and XRay Procedures (Non-Urgent Only)	Paid in Full[3]	Available In-Network Only
D. For Common Communicable Diseases as per CDC Guidelines excluding those used for Foreign Travel	Paid in Full	Available In-Network Only

SERVICES PROVIDED	IN-NETWORK[1]	OUT-OF-NETWORK[2]
4. URGENT CARE CENTER *(Must be an unexpected illness or injury where services are needed sooner than a routine doctor's visit)*		
	Deductible & 10% Coinsurance	
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 & 15% Coinsurance	
Other Associated Charges	Deductible & 15% Coinsurance	
6. INPATIENT HOSPITAL		
A. Inpatient Care (Semi-Private Accommodations Unless Private Accommodations are Approved for Medical Reasons)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
B. Limitation on Inpatient Days	Unlimited	
C. Other Associated Charges	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
7. TRANSPLANT SERVICES Using Institutes of Excellence Network		
Inpatient Services and Other Associated Charges	Deductible & 10% Coinsurance	Available In-Network Only
8. OUTPATIENT HOSPITAL		
Outpatient Procedures	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
Other Associated Charges	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
9. SKILLED NURSING FACILITY		
Skilled Nursing / Rehabilitation Facility (180 Days Per Year Combined Maximum)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
10. HOME HEALTH SERVICES		

SERVICES PROVIDED	IN-NETWORK[1]	OUT-OF-NETWORK[2]
Medically Necessary Services Approved By Claims Administrator (90 Visits Per Year Maximum)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
11. AMBULANCE TRANSPORTATION		
Local Ground or Air Transportation When Medically Necessary To and/or From a Hospital	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance
12. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
A. Inpatient Acute Care for Non-Biologically Based Mental Illnesses	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
B. Inpatient Care for Biologically Based Mental Illnesses	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
C. Outpatient Treatment for Non-Biologically Based Mental Health Illnesses	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
D. Outpatient Treatment for Biologically Based Mental Illnesses	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
13. SPEECH THERAPY		
Medically Necessary Restorative Services, Non-developmental Conditions except under age 5 (40 Visits Per Year Maximum)	Deductible & 10% Coinsurance	Deductible & 35% 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 & 10% Coinsurance	Deductible & 35% Coinsurance
15. CHIROPRACTIC CARE		
26 Spinal Manipulations Per Year Maximum	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance

SERVICES PROVIDED	IN-NETWORK[1]	OUT-OF-NETWORK[2]
16. ACUPUNCTURE		
Medically Necessary Acupuncture Services (20 Visits Per Year Maximum)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
17. DURABLE MEDICAL EQUIPMENT		
Medically Necessary Equipment, Prosthetic Appliances, and Medical Supplies	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance
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*[4].	***Retail Pharmacy Network:*** $6 (Tier 1), Deductible & 20% with $30 minimum/$125 maximum (Tier 2), and Deductible & 20% with $60 minimum/$175 maximum (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 maximum (Tier 2), and Deductible & 20% with $175 maximum (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 Pharmacy, Emily Couric Clinical Cancer Center Pharmacy, UVA Bookstore Pharmacy, Zion Crossroads Pharmacy, and UVA Cancer Center Augusta Pharmacy. ***OptumRx Home Delivery:*** $14 (Tier 1), 15% with $60 minimum/$325 maximum (Tier 2), and 15% coinsurance with $120 minimum/$375 maximum (Tier 3) cost sharing per prescription for up to *90-day supply through mail order*. *31- to 90-day supply* may be purchased at *Participating Retail Pharmacies* with no discounted copayment. 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 maximum (Tier 1), 20% with $125 maximum (Tier 2), and 20% with $175 maximum (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[4]. 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 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. Per Individual	$400	$1,200
B. Per Family	$800	$2,400

SERVICES PROVIDED	IN-NETWORK[1]	OUT-OF-NETWORK[2]
20. MAXIMUM OUT-OF-POCKET	Includes Coinsurance, Deductible, Copayments, and covered Prescriptions; Excludes Amounts above the Allowable Amount[4].	
A. Per Individual	$5,500	$11,000
B. Per Family	$11,000	$22,000

[1]Participants living outside the United States for 90 consecutive days or longer who complete a special Foreign Country Enrollment Form available from the UVA Total Rewards Division may use providers in the country in which they are residing as in-network providers for health services with the exception of transplants. All transplant services must be performed by Aetna Institutes of Excellence Network Providers. Health services received in the U.S. must be provided by Aetna participating providers to be eligible for in-network benefits.

[2]OON 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

[3]Choice Health 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.

[4]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 out-of-pocket amount. Neither is cost-sharing for non-covered prescriptions or services.