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

Coverage for: EE Only; EE+ 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?	Network: 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 providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: EE Only $4,000; EE+Family: $8,000. Out–of–Network: EE Only $8,000; EE+Family: $16,000.	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, penalties for failure to obtain pre-authorization for services & health care this plan doesn't cover.	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 network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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.

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% coinsurance	40% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	20% coinsurance	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	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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)	
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.mycatamaranrx.com	Tier 1 drugs (generic drugs)	20% coinsurance	Member pays full cost of medication then files claim to be reimbursed for all but the applicable coinsurance.	Covers 90 day supply. Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Mandatory generic substitution. 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. **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).
	Tier 2 drugs (formulary brand-name drugs)	20% coinsurance	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% coinsurance	Member pays full cost of medication then files claim to be reimbursed for all but the applicable coinsurance.	
	Specialty drugs	20% coinsurance	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	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	40% coinsurance for non-emergency transport.
	Urgent care	20% coinsurance	20% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office and other outpatient services: 20% coinsurance	Office & other outpatient services: 40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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	Home health care	20% coinsurance	40% coinsurance	Limited to 90 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	40% coinsurance	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.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 180 days/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	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
	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) 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 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**
Cost Sharing	
Deductibles*	$2,000
Copayments	$0
Coinsurance	$2,527
What isn't covered	
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**
Cost Sharing	
Deductibles*	$2,000
Copayments	$0
Coinsurance	$1,437
What isn't covered	
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**
Cost Sharing	
Deductibles*	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
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.