

**University of Virginia Health Plan
2022 Schedule of Benefits
Choice Health**

Covered Services	In-Network ¹	Out-of-Network ²
<i>Annual Deductible</i>	Applies to services and covered prescriptions that have coinsurance; not applicable to services or prescriptions that have copayments or to amounts above the allowable amount or to penalties. ³	
Individual	\$500	\$1,500
Family	\$1,000	\$3,000
<i>Out-of-Pocket Maximum</i>	Includes coinsurance, deductible, copayments, and covered prescriptions; not applicable to amounts above the allowable amount or penalties. ³	
Individual	\$5,500	\$11,000
Family	\$11,000	\$22,000
<i>Plan Coinsurance</i>	Applies to all expenses unless otherwise stated.	
	Deductible & 15%	Deductible & 35%
<i>Professional Services in Office or Outpatient</i>		
<i>Primary care physician (PCP) visit</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Specialty care visit</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Maternity visit (routine prenatal)</i>	Plan pays 100% ⁴	Deductible & 35% coinsurance
<i>Outpatient Procedures</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Other associated charges</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Teladoc Consultations</i>	Using Teladoc provider network only	
<i>Virtual access to doctors for general medicine, behavioral healthcare, dermatology, and caregiving</i>	Deductible & 15% coinsurance	Not available
<i>Preventive Care and Immunizations</i>		
<i>Preventive general physical exam (PCP only)</i>	Plan pays 100%	Not covered
<i>Preventive well child care (under age 7) (PCP only)</i>	Plan pays 100%	Not covered
<i>Preventive diagnostic tests, laboratory services and X-ray procedures (non-urgent only)</i>	Plan pays 100% ⁴	Not covered
<i>Routine cancer screenings</i>	Plan pays 100% ⁴	Not covered

Covered Services	In-Network¹	Out-of-Network²
<i>For common communicable diseases as per CDC guidelines excluding those used for foreign travel</i>	Plan pays 100%	Not covered
<i>Urgent Care Center</i>	Must be an unexpected illness where services are needed sooner than a routine doctor's visit.	
	Deductible & 15% coinsurance	
<i>Emergency Room Services</i>	Must be an emergency to receive benefits. If admitted, benefits will be processed under the hospital care benefits.	
<i>Emergency room visit</i>	Deductible & 20% coinsurance	
<i>Other associated charges</i>	Deductible & 20% coinsurance	
<i>Inpatient Hospital</i>		
<i>Inpatient care (semi-private accommodations unless private accommodations are approved for medical reasons)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Limitation on inpatient days</i>	Unlimited	
<i>Other associated charges</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Transplant Services</i>	Using Aetna's Institutes of Excellence network only	
<i>Inpatient services and other associated charges</i>	Deductible & 15% coinsurance	Not available
<i>Bariatric Services</i>	Using Aetna's Institutes of Quality network only	
<i>Inpatient services and other associated charges</i>	Deductible & 15% coinsurance	Not available
<i>Outpatient Hospital</i>		
<i>Outpatient procedures and other associated charges</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Early Intervention Services</i>	Lifetime maximum of \$5,000 per covered member for all covered medical services	
<i>Primary care physician (PCP) visit</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Specialty care visit</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Infertility Services</i> <i>Comprehensive Infertility and Advanced Reproductive Technology</i>	Lifetime maximum of \$15,000 for medical and Rx services per subscriber and their covered spouse; no coverage for dependent children	
<i>Treatment after diagnosis</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Skilled Nursing Facility</i>		
<i>Skilled nursing/rehabilitation facility (180 days per year combined, maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Hospice Care</i>		

Covered Services	In-Network¹	Out-of-Network²
<i>Inpatient and outpatient services</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Home Health Services</i>		
<i>Medically necessary services approved by Claims Administrator (90 visits per year maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Ambulance Transportation</i>		
<i>Local ground or air transportation when medically necessary to and/or from a hospital</i>	Deductible & 15% coinsurance	Deductible & 15% coinsurance
<i>Mental Health and Substance Abuse Services</i>		
<i>Inpatient hospital and residential treatment</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Outpatient treatment</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Speech Therapy</i>		
<i>Medically necessary restorative services, non-developmental conditions (40 visits per year maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Physical and Occupational Therapy</i>		
<i>Medically necessary restorative services, non-developmental conditions (40 visits per year combined maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Habilitation Therapy for children through age 4</i>		
<i>Medically necessary services under age 5 (speech and occupational therapy)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Chiropractic Care</i>		
<i>Spinal manipulations (26 per year maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Acupuncture</i>		
<i>Medically necessary acupuncture services (20 visits per year maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Hearing Services</i>		
<i>Hearing Exam performed by an audiologist (1 per year maximum)</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Medically necessary hearing aids up to \$1,200 every 48 months</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance
<i>Durable Medical Equipment</i>		

Covered Services	In-Network¹	Out-of-Network²
<i>Medically necessary equipment, prosthetic appliances and medical supplies</i>	Deductible & 15% coinsurance	Deductible & 35% coinsurance

Covered Drugs³	UVA Pharmacies⁵	Aetna National Pharmacy Network
<i>Prescription Drugs</i>		
<p>Covered drugs are evaluated and selected from Aetna’s Standard Plan Formulary. They require a written prescription and approval by the FDA.</p> <p>Participating pharmacy cost-sharing using Aetna National Pharmacy Network pharmacies is detailed on this schedule.</p> <p>The Plan mandates generic substitution. Coverage is limited to the cost of the generic when available. When a generic equivalent exists for a brand name prescription, you 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.³</p> <p>Maintenance drugs for chronic conditions must be filled through the Maintenance Choice program with Opt-Out. This program allows 90-day scripts of maintenance drugs to be filled at UVA and CVS Pharmacies and CVS Caremark Mail Service Pharmacy. You must opt-out of Maintenance Choice if you want to fill a 30-day script of maintenance drugs at other retail pharmacies.</p> <p>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.</p>		
<i>Retail Pharmacy</i>	<i>Up to 30-day supply</i>	
<i>Generic drugs</i>	\$6 copay	\$6 copay
<i>Preferred brand drugs</i>	Deductible & 20% coinsurance (\$150 maximum)	Deductible & 20% coinsurance (\$34 minimum/\$150 maximum)
<i>Non-preferred brand drugs</i>	Deductible & 20% coinsurance (\$225 maximum)	Deductible & 20% coinsurance (\$68 minimum/\$225 maximum)
<i>Maintenance Choice program with Opt-Out⁶</i>	<i>90-day supply</i>	<i>CVS Caremark Mail Service Pharmacy and CVS Retail Pharmacies</i>
<i>Generic drugs</i>	\$14 copay	\$14 copay
<i>Preferred brand drugs</i>	Deductible & 15% coinsurance (\$375 maximum)	Deductible & 15% coinsurance (\$75 minimum/\$375 maximum)
<i>Non-preferred brand drugs</i>	Deductible & 15% coinsurance (\$475 maximum)	Deductible & 15% coinsurance (\$150 minimum/\$475 maximum)

Covered Drugs ³	UVA Pharmacies ⁵	Aetna National Pharmacy Network
<i>Specialty Drugs must be filled through UVA Specialty Pharmacy (Limited Distribution Drugs can also be filled through CVS Specialty Pharmacy)</i>	<i>Up to 30-day supply</i>	<i>CVS Specialty Pharmacy (Limited Distribution Specialty Drugs only)</i>
Generic drugs	Deductible & 20% coinsurance (\$100 maximum)	Deductible & 20% coinsurance (\$100 maximum)
Preferred brand drugs	Deductible & 20% coinsurance (\$150 maximum)	Deductible & 20% coinsurance (\$150 maximum)
Non-preferred brand drugs	Deductible & 20% coinsurance (\$200 maximum)	Deductible & 20% coinsurance (\$200 maximum)
Diabetic drugs, insulin, and supplies	30-day supply at an Aetna National Network Pharmacy	90-day supply through Maintenance Choice
Generic drugs	\$0	\$0
Preferred brand drugs	\$34	\$75
Non-preferred brand drugs	Deductible & 20% coinsurance (\$68 minimum/\$225 maximum); through UVA Pharmacies, Deductible & 20% coinsurance (\$225 maximum)	Deductible & 15% coinsurance (\$150 minimum/\$475 maximum); through UVA Pharmacies, Deductible & 15% coinsurance (\$475 maximum)

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 HR may use providers in the country in which they are residing as in-network providers for health services with the exception of transplants and bariatric services. Aetna Institutes of Excellence Network Providers must perform all transplant services. Aetna Institutes of Quality Network Providers must perform all bariatric service. Health services received in the U.S. must be provided by Aetna participating providers to be eligible for in-network benefits.

² Out-of-network 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 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 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.

⁴ Choice Health will pay 100% of in-network preventive diagnostic, laboratory and X-ray procedures. The plan coinsurance will be applied for in-network non-preventive diagnostic, laboratory and X-ray procedures after the annual deductible has been met.

⁵ UVA Pharmacies include UVA Pharmacy at ERC, UVA Bookstore Pharmacy, UVA Student Health Pharmacy, Zion Crossroads Pharmacy, UVA Cancer Center Augusta Pharmacy, UVA Pharmacy Pantops, and UVA Specialty Pharmacy.

- ⁶ Participants can opt out of the Maintenance Choice program for all their maintenance medications. Contact Aetna at 800-987-9072 before your third fill of maintenance medications and you can continue to fill a 30-day supply at your retail pharmacy at the regular retail costshare amount.