# UNIVERSITY OF VIRGINIA HEALTH PLAN
# MEDICAL SCHEDULE OF BENEFITS
# 2010

| | HIGH PREMIUM PROGRAM | | LOW PREMIUM PROGRAM | |
|---|---|---|---|---|
| **SERVICES PROVIDED** | **IN-NETWORK*** | **OUT-OF-NETWORK**** | **IN-NETWORK*** | **OUT-OF-NETWORK**** |
| | **Direct Access through SHS network providers** | **Care provided by non-participating providers** | **Direct Access through SHS network providers** | **Care provided by non-participating providers** |
| **1. PROFESSIONAL SERVICES IN OFFICE OR OUTPATIENT** | | | | |
| A. Primary Care Physician Visit | $20 Copayment | Deductible & 25% Coinsurance | $20 Copayment | Deductible & 40% Coinsurance |
| B. Specialty Care Visit | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| C. Maternity Visit | $20 Copayment for 1st visit only | Deductible & 25% Coinsurance | $20 Copayment for 1st visit only | Deductible & 40% Coinsurance |
| D. Allergy Treatment, Allergy Serum & Allergy Injections | $20 PCP/$40 Specialist Copayment | Deductible & 25% Coinsurance | $20 PCP/$40 Specialist Copayment | Deductible & 40% Coinsurance |
| **2. PREVENTIVE CARE AND IMMUNIZATIONS** | | | | |
| A. General Physical Examination (PCP Only) | $20 Copayment | Available In-Network Only | $20 Copayment | Available In-Network Only |
| B. Well Child Care (Under Age 7) (PCP Only) | $20 Copayment | Available In-Network Only | $20 Copayment | Available In-Network Only |
| C. Preventive Diagnostic Tests, Laboratory Services and XRay Procedures | Paid in Full | Available In-Network Only | Paid in Full | Available In-Network Only |

| SERVICES PROVIDED | HIGH PREMIUM PROGRAM IN-NETWORK* | HIGH PREMIUM PROGRAM OUT-OF-NETWORK** | LOW PREMIUM PROGRAM IN-NETWORK* | LOW PREMIUM PROGRAM OUT-OF-NETWORK** |
|---|---|---|---|---|
| D. For Common Communicable Diseases as per CDC Guidelines (Adenovirus, Diphtheria, Hepatitis B, HPV, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumonia, Poliomyelitis, Rubella, Tetanus, and Varicella) excluding those used for Foreign Travel | Paid in Full (Also considered in-network when performed by university/college student health dept.) | Available In-Network Only | Paid in Full (Also considered in-network when performed by university/college student health dept.) | Available In-Network Only |
| **3. DIAGNOSTIC, LABORATORY AND XRAY PROCEDURES** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| A. Diagnostic Tests, Laboratory Services and XRay Procedures | Deductible & 10% Coinsurance[1] | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance[2] | Deductible & 40% Coinsurance |
| B. Typical Prenatal Diagnostic Tests, Laboratory Services and XRay Procedures | Paid in Full | Deductible & 25% Coinsurance | Paid in Full | Deductible & 40% Coinsurance |
| **4. URGENT CARE CENTER** *(Must be an unexpected illness or injury where services are needed sooner than a routine doctor's visit)* | | | | |
| A. Physician Visit | $40 Copayment | $40 Copayment | $40 Copayment | $40 Copayment |
| B. Diagnostic Services | Deductible & 10% Coinsurance | Deductible & 10% Coinsurance | Deductible & 20% Coinsurance | Deductible & 20% 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.)* | | *(Must be an emergency to receive benefits.)* | |
| A. Emergency Room Visit | $125 Copayment | | Deductible & 20% Coinsurance | |
| B. Emergency Room Physician Services | $40 Copayment | | Deductible & 20% Coinsurance | |
| C. Diagnostic Services | Deductible & 10% Coinsurance | | Deductible & 20% Coinsurance | |
| **6. INPATIENT HOSPITAL** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| A. Inpatient Care (Semi-Private Accommodations Unless Private Accommodations are Approved for Medical Reasons) | $300 Copayment per confinement | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| B. Medically Necessary Intensive Care | Paid in Full | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |

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|---|---|---|---|---|
| C. Limitation on Inpatient Days | Unlimited | Unlimited | Unlimited | Unlimited |
| D. Other Inpatient Services Including Pre-Admission Testing | Paid in Full | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **7. TRANSPLANT SERVICES** Using national transplant network | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| A. Inpatient Services | $300 Copayment per confinement | Available In-Network Only | Deductible & 20% Coinsurance | Available In-Network Only |
| B. Diagnostic Tests, Laboratory Services and XRay Procedures | Deductible & 10% Coinsurance | Available In-Network Only | Deductible & 20% Coinsurance | Available In-Network Only |
| **8. OUTPATIENT HOSPITAL** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| A. Outpatient Procedures | $125 Copayment per visit | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| B. Diagnostic Services (including but not limited to xrays, EKG, MRI, CAT scans, DEXA scans) | Deductible & 10% Coinsurance | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **9. SKILLED NURSING FACILITY*** ** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| A. Skilled Nursing / Rehabilitation Facility (180 Days Per Year Combined Maximum) | Paid in Full | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| B. Physician Visit | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| **10. HOME HEALTH SERVICES*** ** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| Medically Necessary Services Approved By Claims Administrator (90 Visits Per Year Maximum) | Paid in Full | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **11. AMBULANCE TRANSPORTATION** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| Local Ground or Air Transportation When Medically Necessary To and/or From a Hospital | Paid in Full | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |

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| **12. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| A. Inpatient Acute Care for Non-Biologically Based Mental Illnesses | $300 Copayment per confinement | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| B. Inpatient Care for Biologically Based Mental Illnesses | $300 Copayment per confinement | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| C. Outpatient Treatment for Non-Biologically Based Mental Health Illnesses | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| D. Outpatient Treatment for Biologically Based Mental Illnesses | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| **13. SPEECH THERAPY*****  | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Maximum) | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| **14. PHYSICAL/ OCCUPATIONAL THERAPY***** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |
| Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Combined Maximum) | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| **15. CHIROPRACTIC CARE***** | | | | |
| 26 Spinal Manipulations Per Year Maximum, $600 maximum per year | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| **16. ACUPUNCTURE***** | | | | |
| Medically Necessary Acupuncture Services (20 Visits Per Year Maximum) | $40 Copayment | Deductible & 25% Coinsurance | $40 Copayment | Deductible & 40% Coinsurance |
| **17. DURABLE MEDICAL EQUIPMENT** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** | **Preauthorization Required** |

| SERVICES PROVIDED | HIGH PREMIUM PROGRAM IN-NETWORK* | HIGH PREMIUM PROGRAM OUT-OF-NETWORK** | LOW PREMIUM PROGRAM IN-NETWORK* | LOW PREMIUM PROGRAM OUT-OF-NETWORK** |
|---|---|---|---|---|
| Medically Necessary Equipment, Prosthetic Appliances, and Medical Supplies | 20% Coinsurance | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **18. PRESCRIPTION DRUGS** | | | | |
| For All Covered Medications Requiring a Written Prescription, at Participating Pharmacies (Mandatory Generic Substitution: Coverage is limited to cost of Generic when available) | $6 (Generic), Deductible & 20% with $24 minimum/$100 maximum (Formulary), and Deductible & 20% with $48 minimum/$100 maximum (Non-Formulary) cost sharing per prescription for up to a 30-day supply at Participating Pharmacies only; $100 annual deductible for brand retail drugs. $14 (Generic), 20% with $56 minimum/$300 maximum (Formulary), and 20% coinsurance with $112 minimum/$300 maximum (Non-Formulary) cost sharing per prescription for up to 90-day supply through mail order. 31- to 90-day supply may be purchased at select Retail Maintenance Pharmacies with no discounted copayment. Contraceptive drugs and devices are covered. 100% Coinsurance per prescription at Participating Pharmacies only for most non-covered prescription drugs approved by FDA as non-investigational or non-experimental. Over-the-counter items are not covered.<br><br>**Specialty Drugs**: available only in a supply up to 30 days; 20% with $50 minimum/$100 maximum cost sharing per prescription. Specialty Drugs must be filled through CVS Caremark Specialty Pharmacy.<br><br>*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.* | | | |
| **19. SERVICES NOT SPECIFIED ABOVE AND DRUGS ASSOCIATED WITH THESE SERVICES** | | | | |
| Including but not limited to: Accident, Blood Administration, Cardiac Rehab, Chemo-therapy, Contraceptive outpatient services, Dental Injury, Dialysis, Diaphragm outpatient services, Eye Exams for diabetics, Health Education, Infertility Testing up to the initial diagnosis, Infusion IV Therapy, IUD outpatient services, Norplant outpatient services, Organ Transplant Diagnostic Services, Regis-tered Nurse, Respiratory Therapy, and Therapeutic Injections. | Deductible & 10% Coinsurance | Deductible & 25% Coinsurance | Deductible & 20% Coinsurance | Deductible & 40% Coinsurance |
| **20. MAXIMUM LIFETIME BENEFIT PER PERSON*** ** | $2,000,000 | | $2,000,000 | |

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|---|---|---|---|---|
| SERVICES PROVIDED | IN-NETWORK* | OUT-OF-NETWORK** | IN-NETWORK* | OUT-OF-NETWORK** |
| **21. MAXIMUM LIFETIME BENEFIT PER PERSON FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE*** ** | Included in the $2,000,000 lifetime maximum. | | Included in the $2,000,000 lifetime maximum. | |
| **22. CALENDAR YEAR DEDUCTIBLE*** ** | (Deductible is applicable to services that have Coinsurance; deductible is not applicable to medical services that have Copayments or to Prescriptions, Dental Services, and Amounts above the Allowable Charge.) | | (Deductible is applicable to services that have Coinsurance; deductible is not applicable to medical services that have Copayments or to Prescriptions, Dental Services, and Amounts above the Allowable Charge.) | |
| A. Per Individual | $100 | $300 | $350 | $700 |
| B. Per Family | $200 | $600 | $700 | $1,400 |
| **23. MAXIMUM OUT-OF-POCKET COINSURANCE*** ** | (Includes Coinsurance; Excludes Deductible, Copayments, Prescriptions, Dental, and Amounts above the Allowable Charge) | | (Includes Coinsurance; Excludes Deductible, Copayments, Prescriptions, Dental, and Amounts above the Allowable Charge) | |
| A. Per Individual | $2,500 | $5,000 | $3,500 | $7,000 |
| B. Per Family | $5,000 | $10,000 | $7,000 | $14,000 |
| **24. PENALTY FOR FAILURE TO OBTAIN PREAUTHORIZATION** | Claim Denial | Claim Denial | Claim Denial | Claim Denial |

* Participants in National Network and Out-of-Area Groups and Exceptions are responsible for obtaining any necessary Preauthorization. Failure to obtain Preauthorization will result in a 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.
** OON cost sharing amounts are based on the Allowable Charge as defined in the Section titled "Definitions" in the Description of Benefits. Participants are responsible for amounts above the Allowable Charge 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 will 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
*** The annual and lifetime counters associated with these benefits are reset to zero when a participant moves from one policy to another.

[1] The High Premium Program will pay 100% of in-network **preventive** diagnostic, laboratory, and xray procedures. 90% payment will be made for in-network non-preventive diagnostic, laboratory, and xray procedures after the annual deductible has been met. The High Premium Program will pay 100% of in-network mammograms and PSA tests whether they are preventive or not.
[2] The Low Premium Program will pay 100% of in-network **preventive** diagnostic, laboratory, and xray procedures. 80% payment will be made for in-network non-preventive diagnostic, laboratory, and xray procedures after the annual deductible has been met.