Description of Benefits for 2010

This document contains the complete current Description of Benefits for 2010.

It consists of:

• 2008 Description of Benefits
• Amendments for 2009
• Amendments for 2010

The amendments are located at the end of the document.

Schedule of Benefits for 2010

• Schedule of Medical Benefits
• Out-of-Area Schedule of Medical Benefits
• National Network Schedule of Medical Benefits

Questions?

Please call the HR Service Center at (434) 982-1023 or visit the HR Website.
University of Virginia Health Plan
Description of Benefits

FOR UNIVERSITY OF VIRGINIA ENROLLEES
Effective January 1, 2008
Table of Contents

UNIVERSITY OF VIRGINIA HEALTH PLAN MEDICAL SCHEDULE OF BENEFITS .................................................. 4
UNIVERSITY OF VIRGINIA HEALTH PLAN DENTAL SCHEDULE OF BENEFITS ........................................... 9
ABOUT YOUR BENEFITS ........................................................................................................................................ 11
Your Plan Document ........................................................................................................................................... 11
Purpose of the Plan .................................................................................................................................................. 11
Who to Contact with Questions About Your Benefits ......................................................................................... 11
YOUR RIGHTS AND RESPONSIBILITIES ............................................................................................................. 12
Participant Bill of Rights ......................................................................................................................................... 12
Your Responsibilities as a Participant .................................................................................................................. 13
ELIGIBILITY .......................................................................................................................................................... 14
Employees .............................................................................................................................................................. 14
Dependents ............................................................................................................................................................ 15
Retirees .................................................................................................................................................................... 16
When Coverage Begins .......................................................................................................................................... 16
When Coverage Ends ........................................................................................................................................... 17
ENROLLING IN YOUR BENEFITS .......................................................................................................................... 19
New Hire Enrollment ............................................................................................................................................... 19
Choosing a Coverage Level ................................................................................................................................... 20
Annual Open Enrollment ....................................................................................................................................... 20
Mid-Year Qualifying Event Changes .................................................................................................................. 21
WHAT HAPPENS IF ............................................................................................................................................. 23
If You Get Married ................................................................................................................................................ 23
If You Have a Baby or Adopt a Child ..................................................................................................................... 23
If You Enter Active Military Service ................................................................................................................... 24
If You Become Divorced ....................................................................................................................................... 24
If Your Child Loses His or Her Eligibility ........................................................................................................... 25
If Your Spouse Or Child Dies .................................................................................................................................. 26
If You Lose Eligibility Under The Plan ................................................................................................................ 26
If You Become Eligible for Medicare (Active Employees Only) ............................................................................ 26
If You Die ................................................................................................................................................................ 26
If You Retire From Active Employment ............................................................................................................. 27
If You Need Emergency Care or Need Care While Traveling Out of Area ........................................................ 27
If You or a Dependent Move Away From the Area for More than 90 Days ......................................................... 30
CONTINUATION OF BENEFITS (COBRA) ......................................................................................................... 31
Qualifying Events .................................................................................................................................................... 31
When COBRA Continuation Coverage Ends ..................................................................................................... 32
Coverage Period ....................................................................................................................................................... 32
Notification Requirements ..................................................................................................................................... 33
How to Elect COBRA Coverage ........................................................................................................................ 34
Making Changes to Your COBRA Coverage ...................................................................................................... 35
HOW THE PLAN WORKS ........................................................................................................ 36
Paying for Services ................................................................................................................ 38
PHYSICIAN OFFICE VISIT AND OUTPATIENT COVERAGE ........................................... 44
Your Coverage .................................................................................................................... 44
PHYSICIAN’S AND SURGICAL BENEFITS ........................................................................ 48
Your Coverage .................................................................................................................... 48
HOSPITAL CARE ................................................................................................................ 51
Your Coverage .................................................................................................................... 51
SKILLED NURSING FACILITY, HOME HEALTH AND HOSPICE CARE ................... 55
Your Coverage .................................................................................................................... 55
OTHER MEDICAL SERVICES ............................................................................................. 57
Your Coverage .................................................................................................................... 57
Durable Medical Equipment, Prosthetic Appliances and Medical Supplies .................... 57
Coverage for Clinical Trials for Treatment Studies on Cancer ........................................ 58
Breast Reconstruction in Connection with Mastectomy ..................................................... 59
MENTAL HEALTH AND SUBSTANCE ABUSE CARE .................................................... 60
Limits on Treatment .......................................................................................................... 60
Psychological Testing ........................................................................................................ 62
Emergency Care ................................................................................................................ 62
PRESCRIPTION DRUGS ..................................................................................................... 63
How the Prescription Drug Plan Works ............................................................................. 63
How to Fill Your Prescription ........................................................................................... 64
Preauthorization .................................................................................................................. 64
Injectables and Specialty Medications ................................................................................ 64
Drugs that Are Not Covered .............................................................................................. 65
DENTAL CARE ................................................................................................................... 66
Your Coverage .................................................................................................................... 66
Limitations .......................................................................................................................... 68
Dental Services that Are Not Covered ............................................................................... 68
WHAT THE PLAN DOES NOT COVER ............................................................................. 69
COORDINATION OF BENEFITS (COB) .......................................................................... 75
Methods of Coordination .................................................................................................... 75
Other Health Care Benefit Plans that this Plan Coordinates With .................................. 76
Right to Coordinate Benefits ............................................................................................. 76
Right to Receive and Release Necessary Information ..................................................... 77
Payments to Other Health Benefits Programs .................................................................. 77
Coordination of Benefits with Automobile Insurance ...................................................... 77
Coordination of Benefits in Transplant Cases ................................................................... 77
Coordination of Benefits with Medicare ........................................................................... 77
# Medical Schedule of Benefits

## HIGH PREMIUM PROGRAM

<table>
<thead>
<tr>
<th>In-Network*</th>
<th>Out-of-Network**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Access through SHS network providers</td>
<td>Care provided by non-participating providers</td>
</tr>
</tbody>
</table>

## LOW PREMIUM PROGRAM

<table>
<thead>
<tr>
<th>In-Network*</th>
<th>Out-of-Network**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Access through SHS network providers</td>
<td>Care provided by non-participating providers</td>
</tr>
</tbody>
</table>

## 1. PROFESSIONAL SERVICES IN OFFICE OR OUTPATIENT

### A. Primary Care Physician Visit
- **$15 Copayment**
- **Deductible & 25% Coinsurance**
- **$15 Copayment**
- **Deductible & 40% Coinsurance**

### B. Specialty Care Visit
- **$30 Copayment**
- **Deductible & 25% Coinsurance**
- **$30 Copayment**
- **Deductible & 40% Coinsurance**

### C. Maternity Visit
- **$15 Copayment for 1st visit only**
- **Deductible & 25% Coinsurance**
- **$15 Copayment for 1st visit only**
- **Deductible & 40% Coinsurance**

## 2. PREVENTIVE CARE AND IMMUNIZATIONS

### A. General Physical Examination (PCP Only)
- **$15 Copayment**
- **Available In-Network Only**
- **$15 Copayment**
- **Available In-Network Only**

### B. Well Child Care (Under Age 7) (PCP Only)
- **$15 Copayment**
- **Available In-Network Only**
- **$15 Copayment**
- **Available In-Network Only**

### C. Preventive Mammograms and PSA Test
- **Paid in Full**
- **Available In-Network Only**
- **Paid in Full**
- **Available In-Network Only**

### D. For Common Communicable Diseases (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**
- **Available In-Network Only**
- **Paid in Full**
- **Available In-Network Only**

## 3. DIAGNOSTIC, LABORATORY AND XRAY PROCEDURES  Preauthorization Required

### Diagnostic Tests, Laboratory Services and XRay Procedures
- **10% Coinsurance**
- **Deductible & 25% Coinsurance**
- **Deductible & 20% Coinsurance**
- **Deductible & 40% Coinsurance**

### 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

### A. Physician Visit
- **$30 Copayment**
- **Deductible & 25% Coinsurance**
- **$30 Copayment**
- **Deductible & 40% Coinsurance**

### B. Diagnostic Services
- **10% Coinsurance**
- **Deductible & 25% Coinsurance**
- **Deductible & 20% Coinsurance**
- **Deductible & 40% Coinsurance**
## 5. EMERGENCY ROOM SERVICES
*(Must be an emergency to receive benefits.)*
Emergency Room Services will be processed under the Hospital Care Benefits if patient is admitted.

<table>
<thead>
<tr>
<th>Service</th>
<th>HIGH PREMIUM PROGRAM</th>
<th>LOW PREMIUM PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Emergency Room Visit</td>
<td>$75 Copayment</td>
<td>Deductible &amp; 20% Coinsurance</td>
</tr>
<tr>
<td>B. Emergency Room Physician Services</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 20% Coinsurance</td>
</tr>
<tr>
<td>C. Diagnostic Services</td>
<td>10% Coinsurance</td>
<td>Deductible &amp; 20% Coinsurance</td>
</tr>
</tbody>
</table>

## 6. INPATIENT HOSPITAL
*Preauthorization Required*

<table>
<thead>
<tr>
<th>Service</th>
<th>HIGH PREMIUM PROGRAM</th>
<th>LOW PREMIUM PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inpatient Care (Semi-Private Accommodations)</td>
<td>$200 Copayment per confinement</td>
<td>Deductible &amp; 25% Coinsurance</td>
</tr>
<tr>
<td>B. Medically Necessary Intensive Care</td>
<td>Paid in Full</td>
<td>Deductible &amp; 25% Coinsurance</td>
</tr>
<tr>
<td>C. Limitation on Inpatient Days</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>D. Other Inpatient Services</td>
<td>Paid in Full</td>
<td>Deductible &amp; 25% Coinsurance</td>
</tr>
</tbody>
</table>

## 7. OUTPATIENT HOSPITAL
*Preauthorization Required*

<table>
<thead>
<tr>
<th>Service</th>
<th>HIGH PREMIUM PROGRAM</th>
<th>LOW PREMIUM PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Outpatient Procedures</td>
<td>$75 Copayment per visit.</td>
<td>Deductible &amp; 25% Coinsurance</td>
</tr>
<tr>
<td>B. Diagnostic Services</td>
<td>10% Coinsurance</td>
<td>Deductible &amp; 25% Coinsurance</td>
</tr>
</tbody>
</table>

## 8. SKILLED NURSING FACILITY***
*Preauthorization Required*

<table>
<thead>
<tr>
<th>Service</th>
<th>HIGH PREMIUM PROGRAM</th>
<th>LOW PREMIUM PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Skilled Nursing / Rehabilitation Facility</td>
<td>Paid in Full</td>
<td>Deductible &amp; 25% Coinsurance</td>
</tr>
<tr>
<td>B. Physician Visit</td>
<td>$30 Copayment</td>
<td>$30 Copayment</td>
</tr>
</tbody>
</table>

## 9. HOME HEALTH SERVICES***
*Preauthorization Required*

<table>
<thead>
<tr>
<th>Service</th>
<th>HIGH PREMIUM PROGRAM</th>
<th>LOW PREMIUM PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary Services</td>
<td>Paid in Full</td>
<td>Deductible &amp; 25% Coinsurance</td>
</tr>
</tbody>
</table>
## Medical Schedule of Benefits *Continued*

### 2008

<table>
<thead>
<tr>
<th>Service Description</th>
<th>High Premium Program</th>
<th>Low Premium Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Direct Access through SHS network providers</td>
<td>Care provided by non-participating providers</td>
<td>Direct Access through SHS network providers</td>
</tr>
</tbody>
</table>

### 10. AMBULANCE TRANSPORTATION

**Preauthorization Required**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Ground or Air Transportation When Medically Necessary To and/or From a Hospital</td>
<td>Paid in Full</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>Deductible &amp; 20% Coinsurance</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
</tbody>
</table>

### 11. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES***

**Preauthorization Required**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inpatient Care for Non-Biologically Based Mental Illnesses (30 Days Per Year Maximum) <em>Lifetime Maximum of 90 Days for Substance Abuse</em></td>
<td>$200 Copayment per confinement</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>Deductible &amp; 20% Coinsurance</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
<tr>
<td>B. Inpatient Care for Biologically Based Mental Illnesses</td>
<td>$200 Copayment per confinement</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>Deductible &amp; 20% Coinsurance</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
<tr>
<td>C. Outpatient Treatment for Non-Biologically Based Mental Health Illnesses (50 Visits Per Year Maximum)</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
<tr>
<td>D. Outpatient Treatment for Biologically Based Mental Illnesses</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
</tbody>
</table>

### 12. SPEECH THERAPY***

**Preauthorization Required**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Maximum)</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
</tbody>
</table>

### 13. PHYSICAL/ OCCUPATIONAL THERAPY***

**Preauthorization Required**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Maximum)</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
</tbody>
</table>

### 14. CHIROPRACTIC CARE***

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 Spinal Manipulations Per Year Maximum, $600 maximum per year</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>$30 Copayment</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
</tbody>
</table>

### 15. DURABLE MEDICAL EQUIPMENT

**Preauthorization Required**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary Equipment, Prosthetic Appliances, and Medical Supplies</td>
<td>20% Coinsurance</td>
<td>Deductible &amp; 25% Coinsurance</td>
<td>Deductible &amp; 20% Coinsurance</td>
<td>Deductible &amp; 40% Coinsurance</td>
</tr>
</tbody>
</table>
16. 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)

<table>
<thead>
<tr>
<th>In-Network*</th>
<th>Out-of-Network**</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

$9 (Generic), $22 (Formulary), and $44 (Non-Formulary) Copayment per prescription for up to a 30-day supply at Participating Pharmacies only. $21 (Generic), $52 (Formulary), and $103 (Non-Formulary) Copayment 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.

**Specialty Drugs:** available only in a supply up to 30 days; $25 (generic), $50 (Formulary) and $75 (Non-Formulary) Copayment per prescription.

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.

17. MAXIMUM LIFETIME BENEFIT PER PERSON***

<table>
<thead>
<tr>
<th>High Premium Program</th>
<th>Low Premium Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000,000</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

18. MAXIMUM LIFETIME BENEFIT PER PERSON FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE***

| Inpatient substance abuse treatment for non-biologically based mental illnesses has a 90-day lifetime maximum benefit | Included in the $2,000,000 lifetime maximum. Inpatient substance abuse treatment for non-biologically based mental illnesses has a 90-day lifetime maximum benefit |

19. 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 | None | $300 | $350 | $700 |
| B. Per Family | None | $600 | $700 | $1,400 |

20. 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 | Unlimited | Unlimited | $7,000 | $14,000 |

21. 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. 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. 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 above this amount.
## Dental Schedule of Benefits

for Enrollees in Employee and COBRA Groups and Retirees who Choose the Dental Option

2008

Participants are responsible for amounts above the Allowable Amount*

Balance Billing allowed if non-participating providers used

### 1. TYPE A PROCEDURES: DIAGNOSTIC & PREVENTIVE CARE**

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Oral Examinations and Prophylaxis (two per calendar year)</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>B. Dental X-rays (full-mouth or panoramic X-rays once in a 36-month period, unless approved in advance by TPA)</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>C. Bitewing Radiographs (two per calendar year)</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>D. Palliative Emergency Treatment</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>E. Topical fluoride application for children under age 19 (two per calendar year)</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>F. Space maintainers for children under age 19 (after loss of a primary molar or permanent first molar; one per tooth every 3 years)</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>G. Biopsies of oral tissue</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>H. Sealants (occlusal) for children under age 19 (one per tooth every 3 years)</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
<tr>
<td>I. Pulp vitality tests (two per calendar year)</td>
<td>Paid in Full up to Allowable Amount</td>
</tr>
</tbody>
</table>

### 2. TYPE B PROCEDURES: PRIMARY SERVICES**

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Restorative – fillings (one per tooth in a 12 month period)</td>
<td>Deductible &amp; 20% of Allowable Amount</td>
</tr>
<tr>
<td>B. Endodontics - treatment of dental pulp, including root canal therapy</td>
<td>Deductible &amp; 20% of Allowable Amount</td>
</tr>
<tr>
<td>C. Oral Surgery</td>
<td>Deductible &amp; 20% of Allowable Amount</td>
</tr>
<tr>
<td>D. Periodontics (treatment of gum disease)</td>
<td>Deductible &amp; 20% of Allowable Amount</td>
</tr>
<tr>
<td>E. General Anesthesia when medically necessary and administered in</td>
<td>Deductible &amp; 20% of Allowable Amount</td>
</tr>
<tr>
<td>connection with oral surgery</td>
<td></td>
</tr>
</tbody>
</table>

### 3. TYPE C PROCEDURES: MAJOR RESTORATIVE**

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Crowns, inlays and onlays</td>
<td>Deductible &amp; 50% of Allowable Amount</td>
</tr>
<tr>
<td>i. installation;</td>
<td></td>
</tr>
<tr>
<td>ii. recementing after installation (not more than once in a 12-month period);</td>
<td>Deductible &amp; 20% of Allowable Amount</td>
</tr>
<tr>
<td>iii. repair after installation;</td>
<td>Deductible &amp; 20% of Allowable Amount</td>
</tr>
<tr>
<td>iv. replacement</td>
<td>Deductible &amp; 50% of Allowable Amount</td>
</tr>
<tr>
<td>B. Bridges</td>
<td>Deductible &amp; 50% of Allowable Amount</td>
</tr>
<tr>
<td>i. installation;</td>
<td></td>
</tr>
</tbody>
</table>

*continued on following page
Participants are responsible for amounts above the Allowable Amount*

Balance Billing allowed if non-participating providers used

| ii. recementing                  | Deductible & 20% of Allowable Amount |
| iii. repair after installation; | Deductible & 20% of Allowable Amount |
| iii. replacement (must be more than five years after installation but not more than once in five years) | Deductible & 50% of Allowable Amount |

**C. Dentures (Full or Partial)**

| i. installation;                 | Deductible & 50% of Allowable Amount |
| ii. repair after installation;   | Deductible & 20% of Allowable Amount |
| iii. replacement of full denture | Deductible & 50% of Allowable Amount |

**4. TYPE D SPECIAL SERVICES: ORTHODONTICS**

**A. Orthodontia Care**

50% of Allowable Amount

**B. Lifetime Maximum Benefit**

$1000 per person

**5. ANNUAL MAXIMUM BENEFIT** (calendar year)

$1,500 per person for Type A, Type B, and Type C

$1,500 per person for Type D

**6. CALENDAR YEAR DEDUCTIBLES**

$50 per person for either Type B or Type C

* Coinsurance amounts are based on the Allowable Amount as defined in the Section titled “Definitions” in the Description of Benefits. Participants are responsible for amounts above the Allowable Amount if they use non-participating providers. Allowable amounts are different for participating and non-participating providers.

** The annual deductible and counters associated with this benefit is reset to zero when a participant moves from one policy to another.
About Your Benefits

This book contains a description of your health care benefits through the University of Virginia Health Plan. Please read the information carefully so you will understand your benefits before you need them.

This Plan has been established to assist you and your eligible family members with the costs of medical care. It is designed to provide choices in obtaining your health care.

Pursuant to the procedures set forth in this document, the Plan will determine whether a claim for Benefits will be paid, and in what amount. However, any decision regarding medical care (including the choice of a Provider or whether to undergo a particular treatment) is your sole responsibility and not that of the Plan. Not all medically necessary services prescribed by your physician may be covered by the Plan.

The Plan's designation of any Network Provider is not a guarantee or a warranty by the Plan of the services of such Provider. The selection of a Provider, whether Network or non-Network, and the decision to receive or decline health care services is your sole responsibility.

YOUR PLAN DOCUMENT

The University of Virginia hereby adopts this Plan Document as the written description of The University of Virginia Health Plan (the “Plan”). This Plan Document replaces any prior statement of the health care coverages of the Plan and is effective on January 1, 2008. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

PURPOSE OF THE PLAN

The purpose of the Plan is to provide certain Benefits for eligible Employees and retirees of the University of Virginia and their eligible dependents. The Benefits provided by the Plan include: Medical Care, Hospital Care, Mental Health and Substance Abuse Care, Hospice Care, Dental Care and Prescription Drugs. There are no pre-existing condition exclusions.

WHO TO CONTACT WITH QUESTIONS ABOUT YOUR BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Claims Administrator</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Medical Care</td>
<td>Southern Health Services</td>
<td>1-888-975-9557</td>
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<td><a href="http://www.southernhealth.com">www.southernhealth.com</a></td>
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<td>1-866-UVA-3707 (1-866-882-3707)</td>
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<td>Mental Health and Substance</td>
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<td><a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a></td>
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<td>Dental Care</td>
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<td><a href="http://www.ucci.com">www.ucci.com</a></td>
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<td>Plan Eligibility</td>
<td>University Human Resources Benefits</td>
<td>434-924-4392</td>
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<td>Division</td>
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<td>COBRA</td>
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Your Rights and Responsibilities

PARTICIPANT BILL OF RIGHTS

1. You have the right to receive information about the University of Virginia Health Plan, the Plan’s services, practitioners and providers, and your Participant rights and responsibilities.

2. You have the right to every consideration of confidentiality concerning your own claims or medical care.

3. You have the right to expect your provider to inform you about your illness and treatment and to have the information explained or interpreted as necessary.

4. You have the right to make decisions about your plan of care prior to and during the course of treatment.

5. You have the right to Benefits for Medically Necessary services that are covered under the UVa Health Plan.

6. You have the right to prompt and courteous replies to questions regarding access to care, medical benefits, and medical claims.

7. You have the right to know what your health care Benefits are and have this information provided to you in a language you can understand.

8. You have the right to file an appeal for reconsideration of a decision or a complaint about the Plan or about the care provided by participating Network Providers. Furthermore, you have the right to be provided with a defined process for addressing complaints and appeals. Please see Section titled “Complaints and Appeals” in this Description of Benefits for this process.
YOUR RESPONSIBILITIES AS A PARTICIPANT

1. You are responsible for asking questions when you do not understand information or instructions.

2. You are responsible for knowing whether you are seeking care from a Network Provider or Out-of-Network Provider. In addition, you are responsible for knowing the Claims Administrator’s Service Area. If you have any questions, you should contact the Claims Administrator at the phone number located on your ID Card.

3. If you or your dependents will reside outside of areas served by Southern Health Provider Network, you are responsible for enrolling in the out-of-area or national network plan by completing a national network/out-of-area form and following national network/out-of-area guidelines.

4. If you are seeking services from an Out-of-Network Provider, you will be responsible for ensuring that the Claims Administrator has preauthorized the services and to know if they are approved Out-of-Network or In-Network so that you receive Benefits at the maximum Benefit level.

5. You are responsible for verifying with the Claims Administrator that a provider has obtained any necessary Preauthorization.

6. You are responsible for ensuring that your family members are aware of the correct procedures for accessing care before obtaining Benefits through the UVa Health Plan.

7. You are responsible for making all necessary cost-sharing payments to providers as required by this Description of Benefits and the enclosed Schedule of Benefits.

8. You are responsible for notifying the University Human Resources Benefits Division of any change in contact information or dependent eligibility. If you or your dependents will reside over 90 days outside of areas served by the Southern Health Provider Network and wish to enroll in the Out Of Area (OOA) coverage, you must submit your OOA enrollment form to the University Human Resources Benefits Division.

9. You are responsible for giving your providers the complete information needed to care for you, including accurate information regarding your current health care coverage, and for following the plan of treatment agreed upon.

10. You are responsible for providing the University Human Resources Benefits Division with information related to other health insurance coverage you or your spouse or dependents may have.

11. You are responsible for submitting a completed, signed UVa Health Plan application to the University Human Resources Benefits Division within the prescribed timeframe to enroll in the Plan.

12. You are responsible for providing documentation and answering questions at the request of the Plan Administrator that proves eligibility.

13. You are responsible for informing University Human Resources Benefits Division when your dependents are no longer eligible for enrollment in the health plan. You are also responsible for the cost of any incurred claims for ineligible dependents.
You must remove ineligible dependents from the Plan!

If your dependent is no longer eligible for coverage, you must notify the University Human Resources Benefits Division in order to remove your dependent from coverage. You’ll be responsible for paying claims incurred by your dependent; you could be suspended from the plan for up to three years; and your dependent may lose his or her right to continue coverage through COBRA.

Eligibility

FAST FACTS

- In order to be covered under the Plan as an active Employee, you must:
  - be a salaried Employee of the University of Virginia;
  - work at least 20 hours per week or have signed a Flexible Staffing Contract;
  - have an appointment of six months or more if you are a faculty member; and
  - have completed and submitted an enrollment form in a timely fashion.

- Part-time salaried employees who work at least 20 hours per week but less than 32 hours a week are eligible to be covered under the Plan but are required to pay both the employer and employee portion of the health plan premium.

- As long as you are eligible for coverage, your legally married spouse is eligible for coverage as well as your unmarried natural or adopted children or step-children up until the end of the year they turn age 23, provided they meet plan requirements; or beyond the end of the year in which they turn 23 if the child is disabled and meets plan requirements.

- You are eligible to be covered under the Plan as a retiree provided you meet the Plan requirements and you enroll within 31 days of your date of retirement.

What You Need to Do

- You are not automatically covered under the Plan. You must enroll when you are first eligible by completing an Enrollment Application and submitting it to the University Human Resources Benefits Division.

- Dependents are not automatically covered under the Plan under any circumstances. You must enroll your eligible dependents for coverage under the Plan within certain timeframes. Refer to the section titled “Enrolling in Your Benefits” for more information.

- The Plan Administrator may require proof of dependency for any person claiming to be a covered dependent. Contact the University Human Resources Benefits Division for information on verification of dependent eligibility.

- If your dependent is no longer eligible for coverage, you must notify the University Human Resources Benefits Division in order to remove your dependent from coverage. You’ll be responsible for paying claims incurred by your dependent and you could be suspended from the plan for up to three years.

EMPLOYEES

You are eligible to participate in the University of Virginia Health Plan if you are a salaried, full-time or eligible part-time Employee of the University of Virginia. This means that you must be paid a salary, not an hourly rate of pay, and must either be regularly scheduled to work at least 20 hours per week, or must have signed a Flexible Staffing Contract. An Employee who is a member of the faculty must have a University appointment of at least six months in order to be covered under the Plan. An Employee must also complete and submit an enrollment application in a timely fashion to be covered under the Plan.
DEPENDENTS

You may enroll your eligible dependents in the Plan. They will be required to enroll in the same program that you choose for yourself. For Health Plan purposes, your eligible dependents are your spouse and your children, defined as follows:

- **Spouse** - your legally recognized spouse;
- **Children** - your unmarried children under age 23 who live at home with you, live with the other biological parent if the parents are divorced, or live at college or boarding school including:
  - biological children who are eligible to be declared as dependents on your income tax return (notwithstanding the earnings limitation);
  - legally adopted children and children for whom you are the proposed adoptive parent, if they are eligible to be declared as dependents on your income tax return (notwithstanding the earnings limitation);
  - children for whom you are legal guardian with permanent custody and who live with you full time in a regular parent-child relationship and who are eligible are declared as dependents on your most recent income tax return or would be declared as dependents but for the earnings limitation; and
  - step-children who live with you full time in a regular parent-child relationship and who are eligible to be declared as dependents on your income tax return, (not withstanding the earnings limitation).

Coverage for a dependent child who is incapable of self-support due to mental or physical disability may continue beyond age 23 if:

- Proof of the disability is furnished to and must be approved by the Claims Administrator PRIOR to the dependent’s 23rd birthday;
- The child meets all other eligibility requirements for dependents; and
- The child is eligible to be declared as a dependent on your income tax return (notwithstanding the earnings limitation).

Coverage for a new dependent child already over 23 who is capable of self-support due to mental or physical disability may be granted if:

- Documentation of the disability and its onset PRIOR to the child’s 23rd birthday by a physician;
- Evidence that the employer or the other parent has provided health coverage for the child from age 23 to the present;
- The child meets all other eligibility requirements for dependents; and
- The child is eligible to be declared as a dependent on your income tax return (notwithstanding the earnings limitation)

NOTE: The Claims Administrator may require periodic re-certification by a physician and/or a determination of disability from the Social Security Administration.
**Special Cases**

A dependent will not be eligible for coverage under the Plan if either of the child’s biological parents also resides with you, unless the biological parent(s) is (are) a minor who shares custody with you.

If your child, who is covered under this Plan gives birth, your newborn grandchild will not be covered. However, if you, as the child’s grandparent, adopt the child, the child will be covered from the effective date of the adoption as long as all other eligibility criteria are met.

Under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of an Employee-Participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to dependent coverage under this Plan.

**RETIREES**

When you retire, you may be eligible for coverage under the Plan provided you were eligible for enrollment in the Plan on your last day as an active state employee and you are one of the following:

- A retiring state employee eligible for a monthly annuity payment from Virginia Retirement System (VRS) or a periodic benefit payment from the Medical Center Retirement Plan (MCRP) or Faculty Retirement Plan (FRP) programs; and you begin to receive your payments immediately upon retirement; OR

- Approved for long-term disability through the VSDP or other Employer-Sponsored disability plans.

**Enrolling in Retiree Coverage**

If you wish to enroll in the Plan, you must submit an enrollment application to the University Human Resources Benefits Division within 31 days of your retirement date.

You may join the Retiree Group even if you weren’t enrolled in the Plan as an active Employee as long as you were eligible for enrollment in the Plan on your last day as an active state employee. You will only be eligible for single coverage.

Your eligible dependents who are enrolled under your plan on your last day as an active state employee may enroll under your Retiree coverage.

If you do not enroll within 31 days of first becoming eligible as a retiree, you will not have another chance to enroll in the Plan.

**NOTE:** All changes to enrollment as a retiree must be submitted within 31 days instead of the 60 days as stated in this document for Active Employees.

**WHEN COVERAGE BEGINS**

You are considered eligible for coverage on the date you begin Active Work if that day is the first working day of the calendar month. If you begin Active Work on a date other than the first working day of the calendar month, you will be eligible for coverage on the first of the calendar month that next follows the date you begin Active Work.
For example, if you begin Active Work on August 1, you will be eligible for coverage on August 1. If you begin Active Work on September 15, you will be eligible for coverage on October 1.

If you are not Actively at Work on the date coverage would be effective, the effective date of coverage will be deferred until the date you are Actively at Work unless you have a leave status that allows for the maintenance of eligibility for health care benefits such as leave taken under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Contact the University Human Resources Benefits Division for further explanation of applicable rules in the University of Virginia Personnel Policies and Procedures. UVa has the sole and exclusive authority to make determinations regarding eligibility under the Plan.

**WHEN COVERAGE ENDS**

**Employees**
Your coverage will end on the earliest of the following dates:

- The last day of the month in which you terminate employment;
- The last day of the month in which you cease to be in a class of Employees eligible for coverage;
- The last day of the month prior to the month for which you fail to make any required contribution for Employee coverage (including any contribution required under an agreement for the payment of past due contributions or premium amounts);
- The date the Plan is terminated or coverage for all Employees under the Plan is terminated; or
- The date of your death.

**Dependents**
Coverage for a dependent will terminate on the earliest of the following dates:

- The last day of the month in which the person is no longer eligible for coverage under the Plan;
- The last day of the year in which a person no longer qualifies as a dependent because of age (December 31 of the calendar year in which an unmarried dependent reaches age 23);
- The last day of the calendar month in which a dependent marries, ceases to live at home (or live at the home of the other parent if the parents are divorced or live at college or boarding school) or ceases to be eligible to be claimed on your federal income tax and thereby is deemed self-sufficient.
- The last day of the month prior to the month you fail to make any required contribution for dependent coverage (including any contribution required under an agreement for the payment of past due contributions or premium amounts);
- The date all dependent coverage under the Plan terminates or the Plan terminates;
- The date of death of the dependent; or
- The last day of the month following the month in which your death occurs.
Note About a Dependent Becoming Ineligible for Coverage
When a dependent’s coverage terminates, any changes to your level of coverage are subject to IRS Section 125 Regulations. Therefore, if a dependent is no longer eligible and you fail to notify the Plan Administrator within 60 days of the loss of eligibility, the dependent will not be covered as of the date of the loss of eligibility but you will still be required to pay premiums until you submit an enrollment application to make changes to your coverage. If you submit an application within 60 days after the date of loss of eligibility, any applicable premium change will be effective back to the loss of eligibility. If you submit an application more than 60 days after the date of loss of eligibility but within the same plan year, any applicable premium change will be effective the first of the month following receipt of application; however the dependent’s loss of coverage will date back to the loss of eligibility. Employee-Participants with ineligible dependents enrolled on their policy may be suspended from the Plan for up to three years. In addition, the Employee-Participant will be responsible for the cost of incurred claims for ineligible dependents and collection efforts will be undertaken to recover any claim dollars paid by the Plan.

Retirees
A Retiree’s coverage will end on the earliest of the following dates:

- The last day of the month in which a Retiree-Participant waives coverage;
- The last day of the month preceding the first day of the month in which the Retiree-Participant becomes eligible for Medicare;
- The last day of the month preceding the first day of the month for which the Retiree-Participant fails to make a premium payment, in full, when due. Premium payments are due on the first day of the month for which coverage is sought (the coverage period). If any payment is not received within 30 days of the due date, coverage will end. If you pay your premium after the due date but before the end of the 30 day grace period, your coverage under the plan will be suspended as of the first day of the coverage period, and then retroactively reinstated (going back to the first day of the coverage period) when the premium is received. This means that any claim you submit for benefits while your coverage is suspended may be denied, and may have to be resubmitted once your coverage is reinstated.
- The last day of the month in which long-term disability payments end;
- The date the Plan is terminated or coverage for all Retirees under the Plan is terminated; or
- The date of the Retiree-Participant’s death.
Enrolling in Your Benefits

FAST FACTS

• When you enroll in your health program, you select the High or Low Premium program that you and your dependents will participate in and choose the level of coverage you want:
  – Employee Only;
  – Employee Plus Child;
  – Employee Plus Spouse;
  – Family; or
  – Double State.

• During annual Open Enrollment, you can change the health program in which you are enrolled. Any changes you make during Open Enrollment will be effective January 1.

What You Need to Do

• As a new hire, you should enroll yourself and your dependents within the first 60 days of your employment. If you fail to enroll yourself or your dependents within that time frame, you and they will be ineligible for coverage until the following plan year unless you submit an application as described in the “New Hire Enrollment” section below.

• If you acquire a dependent, you should submit an application to enroll your dependent to University Human Resources Benefits Division as soon as possible. If you submit an application more than 60 days after the date you acquire the dependent but within the same plan year, the change will be effective the first of the month following receipt of application.

• If your dependent becomes ineligible for coverage because of marital status, age (such as a dependent child becoming age 23), or the dependency requirements, you must notify the University Human Resources Benefits Division within 60 days of the event in order for your dependent to be eligible to continue coverage under COBRA. (Refer to the Continuation of Coverage/COBRA section for more information.)

• Newborns and newly placed adopted children are NOT automatically covered from date of birth or placement. In order for them to have coverage under your plan, you must enroll them within 60 days of their date of birth or placement for adoption in order for the coverage to be retroactive to the first of the month of the event date. If you submit an application more than 60 days after the date of birth or adoption but within the same plan year, the change will be effective the first of the month following receipt of application.

NEW HIRE ENROLLMENT

When you are first hired, you should enroll yourself and your eligible dependents for coverage under the Plan within 60 days of your Date of Hire. If you submit an application more than 60 days after your date of hire but within the same plan year, the change will be effective the first of the month following receipt of application. If you fail to submit an application within the same plan year, you will be unable to join the Plan until Open Enrollment.

Enrolling Dependents

Coverage for dependents is effective on the date your coverage is effective (“Effective Date”) provided you have selected dependent coverage, enrolled the dependent in the Plan, and have paid any required contribution to the Plan.
Making an enrollment change

You must complete and return an application to the University Human Resources Benefits Division in order to make any Mid-Year Qualifying Event change—changes will not occur automatically. Complete details on Mid-Year Qualifying Event changes are available at the University Human Resources Benefits Division.

If you have no dependents on your Effective Date but later acquire a dependent(s), they should be enrolled for coverage within 60 days from the date you acquired the dependent(s) and the required contribution for dependent coverage must be paid. If you submit an application more than 60 days after the date you acquire a dependent(s) but within the same plan year, the change will be effective the first of the month following receipt of application.

Choosing a Coverage Level

You have four coverage options under the Health Plan. The categories are:

- **Employee Only Coverage** - You may elect this category if you wish only to cover yourself;
- **Employee Plus Child Coverage** - You may elect this category of coverage for yourself and one child;
- **Employee Plus Spouse Coverage** - You may elect this category of coverage for yourself and your spouse;
- **Family Coverage** - This category is available to Employees who wish to cover a spouse and one or more dependent children, or if an Employee wishes to cover himself and more than one dependent child; or
- **Double State Coverage** - This is family coverage for two married State Employees with children. You can elect this coverage if both spouses are active full-time salaried Employees, or who each work 32 hours or more, or are Medical Center part-time Employees who signed flex agreements.

If You Do Not Enroll Your Dependents as a New Hire

If you do not enroll your dependents during the 60 day period after which you are initially eligible, you must wait to enroll them in the Plan at the next Open Enrollment period unless you provide proof of a Mid-Year Qualifying Event - such as marriage, birth, or adoption, as explained below.

Annual Open Enrollment

Open Enrollment typically takes place in the fall, near the end of each year, for coverage in the upcoming Plan Year. During this time, you may:

- Enroll for health care coverage;
- Change your previous election - i.e., enroll in a different program;
- Cancel your own and or your dependent’s coverage; or
- Add dependent coverage.

Any changes you make during annual enrollment take effect on the next January 1 and stay in effect for that full calendar year unless you experience a Mid-Year Qualifying Event. These changes are outlined below, under “Mid-Year Qualifying Events.”
**Mid-Year Qualifying Event Changes**

You may make changes to your benefit election during the Plan Year if you experience a Mid-Year Qualifying Event. These include:

- Marriage, Divorce, or Annulment;
- Birth or adoption/placement for adoption;
- Employment status of Employee, dependent, or spouse which affects eligibility to participate in the employer’s health plan;
- Commencement of or returning from an unpaid leave of absence;
- Dependent satisfies or ceases to satisfy eligibility requirements;
- Judgment, decree or order changing legal custody;
- Cost and/or coverage changes in employee’s, dependent’s or spouse’s health plan;
- Entitlement to or loss of eligibility for Government-sponsored programs; or
- Death of spouse or dependent.

**To Make a Mid-Year Election**

To make a change in your coverage that relates to a Mid-Year Qualifying Event, as determined by the Plan and IRS Section 125 Regulations, you must submit a Health Plan change application and documentation of the Mid-Year Qualifying Event. Examples of official documents include: marriage or death certificates, obituaries, birth certificates, hospital-provided proof of birth letters, divorce decrees and adoption agreements signed by a judge, official letters from employers stating dates employment begins or ends as appropriate, and legal custody orders.

Any coverage changes you make must be consistent with the Mid-Year Qualifying Event. For example, if you get married, you may change your Employee Only coverage level to Employee Plus Spouse or Family, but you may not switch your coverage to the High Premium Program from the Low Premium Program.

Coverage changes will be effective the first of the month following receipt of the application at the University Human Resources Benefits Division, except births and adoptions. Those changes are effective the first of the month in which the birth or adoption takes place if an enrollment application is received within 60 days of the birth or adoption. If you submit an application more than 60 days after the date of birth or adoption, but within the same plan year, the coverage will be effective the first of the month following the Qualifying Event. Enrollment changes being submitted due to ineligibility are also effective the first of the month following the Qualifying Event. Premium changes due to ineligibility are effective the first of the month following receipt of the form if the form is received MORE THAN 60 DAYS AFTER THE QUALIFYING EVENT but within the same Plan Year as the Qualifying Event. Applications for changes in membership must be accompanied by documentation and received in the University.
Human Resources Benefits Division within 60 days of the qualifying event or within the same plan year as the mid-year qualifying event and are effective the first of the month following receipt of the form or that day if the form is received on the first of the month unless they are terminating due to ineligibility.

**Special Enrollment Rights**

There are certain Mid-Year Qualifying Events that provide you with Special Enrollment Rights:

- For birth, adoption, or placement for adoption, you can enroll yourself, the new child, as well as any other eligible dependents not already on your policy. If you make application to add the child within 60 days of the event, the coverage is retroactive to the first of the month of the event date.

- For marriage, you can enroll yourself, your new spouse, and any other eligible dependents not already on your policy. The coverage is effective the first of the month following receipt of the enrollment application at the University Human Resources Benefits Division.

- An additional Special Enrollment Right is granted by a federal law known as HIPAA when eligibility is lost for other coverage or when COBRA coverage is exhausted or terminated. Based on these events, you may enroll yourself, your spouse, and/or your dependents who have lost other coverage within 60 days of the event. The coverage is effective the first of the month following receipt of the enrollment application at the University Human Resources Benefits Division.
What Happens If…

This section describes how your health benefits are affected and what action you must take, if any, if you experience certain family situations such as getting married, having a baby, adopting a child, retiring, and certain health situations, such as if you need emergency care while traveling away from home.

IF YOU GET MARRIED

When you marry, your spouse is not automatically covered under your benefits. You may enroll your spouse for coverage under the University of Virginia Health Plan. An application to add your spouse must be received within the same plan year or within 60 days, whichever is greater, of the date of marriage. Coverage is effective the first of the month following the date of receipt of the application.

If you do not enroll your new spouse within the same plan year or within 60 days, whichever is greater, of the date of your marriage, you will need to wait until the next annual Open Enrollment period. This means your spouse will be without coverage under the UVa Health Plan until the next January 1.

What You Need to Do
To enroll your spouse for coverage, contact the University Human Resources Benefits Division. You will need to complete a UVa Health Plan Application and provide a copy of your marriage certificate.

You may not change your health care program type at this time; you’ll need to wait until the Open Enrollment period to do that.

When Coverage Begins
As long as you submit an application to add your spouse within the same plan year or within 60 days, whichever is greater, of the date of marriage, coverage for your new spouse will be effective the first of the month following the receipt of the application by the University Human Resources Benefits Division.

IF YOU HAVE A BABY OR ADOPT A CHILD

Dependent children are eligible for coverage under the health plan. However, you must submit an application in order for them to be enrolled—they are not automatically covered under your policy.

A newborn child is not automatically covered and must be enrolled in the Plan within 60 days from the date of birth or date of adoption or placement for adoption in order for coverage to be retroactive to the first of the month of the event date.

After 60 days, the dependent may be added as long as an enrollment application and verification are submitted within the same plan year as the date of birth or adoption. Coverage is effective the first of the month following the date of receipt of the application. If you fail to add the dependent within the plan year, you must wait until the next Open Enrollment.

What You Need to Do
To enroll your child for coverage, you must complete a UVa Health Plan Application and provide
a copy of the child’s birth certificate, Hospital provided Proof of Birth letter, or court documentation verifying the adoption. Contact the University Human Resources Benefits Division for information.

You may not change your health care program at this time; you’ll need to wait until the Open Enrollment period to do that.

**When Coverage Begins**
As long as you submit an application to add your child within 60 days of the date of birth or adoption, coverage for your child will be effective the first of the month of the date of birth or adoption. If you submit an application more than 60 days from the date of birth or adoption, but within the same plan year, coverage will be effective the first of the month following the date of receipt of application.

**IF YOU ENTER ACTIVE MILITARY SERVICE**
This Plan complies with the Uniformed Service Employment and Reemployment Rights Act (USERRA). Therefore, if you, as an eligible Employee, go into active military service for 31 days or less, coverage continues for you and your eligible dependents during the period of that leave.

If you go into active military service for more than 31 days, you may be able to continue coverage for yourself and your dependents through COBRA for up to 24 months. You must notify the University Human Resources Benefits Division that you wish to elect continuation coverage for yourself or your eligible dependents under the provisions of USERRA.

In order to have coverage reinstated in the Plan as an active employee after returning from active military service, you must complete a UVa Health Plan application.

<table>
<thead>
<tr>
<th>If your period of service lasted:</th>
<th>You must submit an application for reenrollment by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 days or less</td>
<td>No action is necessary, active coverage continues</td>
</tr>
<tr>
<td>31 days or more</td>
<td>Within the same plan year or within 60 days, whichever is greater, of your return from military leave; coverage is effective the first of the month following receipt of application.</td>
</tr>
</tbody>
</table>

**IF YOU BECOME DIVORCED**
Coverage for your spouse under the Plan ends at the end of the month that you divorce. However, your spouse may elect to continue health care coverage under the Plan by purchasing coverage under COBRA for up to 36 months (refer to the Continuation of Coverage/COBRA section for more information). You or your spouse must notify the University Human Resources Benefits Division within 60 days of the date of the final divorce decree in order for your spouse to be eligible to obtain COBRA continuation coverage.

What You Need to Do
- You will need to complete a UVa Health Plan application to terminate your ex-spouse from the Health Plan and submit it to the University Human Resources Benefits Division within 60 days.
of the date of the divorce so that you will not continue to pay a premium for this coverage. You will also need to provide a copy of the signed pages of the divorce decree verifying the parties involved and the date of divorce, along with your application to terminate coverage.

- A qualified medical child support order (QMCSO) or a qualified domestic relations order (QDRO) could have an effect on your benefit coverage or elections. Please notify the University Human Resources Benefits Division if you become aware of an order like this as part of divorce proceedings.

- Your former spouse should review the COBRA information he or she will receive from the University Human Resources Benefits Division and enroll in coverage within 60 days of receiving the material, if her or she would like to continue coverage under the Plan.

**IF YOUR CHILD LOSES HIS OR HER ELIGIBILITY**

In general, coverage for your dependent child ends on the soonest of the following:

- The last day of the calendar year he or she turns 23;
- The last day of the calendar month in which he or she marries;
- The last day of the calendar month he or she ceases to live in a parent-child relationship with you either at home, at the home of the other parent if the parents are divorced, or at boarding school or college;
- The last day of the calendar month in which he or she ceases to be eligible to be claimed on your federal income tax and thereby is deemed self-sufficient;
- The last day of the calendar month in which your coverage ends due to termination of employment; or
- The last day of the month following the month of your death.

Your child may continue coverage by purchasing coverage under COBRA for up to 36 months or 18 months if coverage ends because of your termination of employment (refer to the Continuation of Coverage/COBRA section for more information). You must notify the University Human Resources Benefits Division within 60 days after your child no longer meets the eligibility requirements in order to be eligible to obtain COBRA continuation coverage and so that you will not continue to pay a premium for this coverage.

If your child is not capable of self-supporting employment because of a physical or mental disability, you may be able to continue coverage for that child for as long as your own coverage continues. To qualify, your child’s disability must begin before his or her coverage would otherwise end. Refer to the “Eligibility” section for more information.

**What You Need to Do**

- You will need to complete a UVa Health Plan application and provide documentation verifying the qualifying event that resulted in the loss of eligibility such as a marriage certificate, post office address change, or letter of employment. Contact the University Human Resources Benefits Division for information.
Your dependent should review the COBRA information he or she will receive from the University Human Resources Benefits Division and enroll in coverage if he or she wishes within 60 days of receiving the material.

**If Your Spouse Or Child Dies**

Notify the University Human Resources Benefits Division within 60 days of the date of death in order to stop coverage, so that you will not continue to pay a premium for this coverage. If you fail to notify the University Human Resources Benefits Division within 60 days, the UVA Health Plan will consider this a clear and convincing error as defined by the IRS, and will allow you to reduce membership once the error is discovered. Premiums will be returned to the employee up to the first of the year in which the error is discovered.

**What You Need to Do**

- You will need to complete a UVa Health Plan application and provide a copy of the death certificate or obituary.

**If You Lose Eligibility Under The Plan**

Generally, coverage for you and your dependents will end on the last day of the month in which you lose your eligibility under the Plan. You are eligible to continue your medical, dental and vision benefits by purchasing coverage through COBRA for up to 18 months. Refer to the “Continuation of Coverage/COBRA” section for more information.

**If You Become Eligible For Medicare**

(Active Employees Only)

You become eligible for Medicare when you reach age 65 or earlier due to a qualified disability. This Plan will pay primary benefits when you are an active employee.

**What You Need to Do**

Refer to the Coordination of Benefits section of this document for more details on how this Plan coordinates with Medicare.

**If You Die**

Your dependents and/or beneficiaries should call the University Human Resources Benefits Division to report your death. Once the death is reported, the surviving spouse or dependents will receive detailed information on benefit continuation.

Coverage for any dependents enrolled in the health plan ends at the end of the month following the month of your death. However, your dependents may continue participation through COBRA by making the appropriate payments.

Dependents have 60 days from the receipt of the COBRA package to decide whether or not to continue coverage under COBRA for up to an additional 36 months (refer to the “Continuation of Coverage/COBRA” section for more information). Only dependents enrolled at the time of an Employee’s death can continue coverage through COBRA.
IF YOU RETIRE FROM ACTIVE EMPLOYMENT

When you retire, you may be eligible for coverage provided you were eligible for enrollment in the Plan on your last day as an active state employee and you are one of the following:

• A retiring state employee eligible for a monthly annuity payment from Virginia Retirement System (VRS) or a periodic benefit payment from the Medical Center Retirement Plan (MCRP) or Faculty Retirement Plan (FRP) programs; and

• You begin to receive your payments immediately upon retirement; or

• You are approved for long-term disability through the VSDP or other Employer-Sponsored disability plans.

NOTE: You may join the Retiree Group even if you weren’t enrolled in the Plan as an active Employee as long as you were eligible for enrollment in the Plan on your last day as an active state employee. You will only be eligible for single coverage.

Enrolling in Retiree Coverage

You must submit an Enrollment/Waiver Form to the University Human Resources Benefits Division within 31 days of your retirement date to enroll in the UVa Health Plan. Note that retirees must enroll separately in dental and vision coverage.

Your eligible dependents who are enrolled under your plan on your last day as an active state employee may enroll under your Retiree coverage.

NOTE: All changes to enrollment as a retiree must be submitted within 31 days instead of the 60 days as stated in this document for Active Employees.

Eligibility for State Health Care Insurance After Retirement

Once you reach age 65 and/or become eligible for Medicare, coverage under the Plan will end.

The Commonwealth of Virginia provides a group Medicare Supplement for retirees who receive VRS, FRP, or MCRP retirement income. The University Human Resources Benefits Division will assist you with the health insurance application if you elect coverage for yourself and dependents at the time you retire. Your spouse will be able to continue coverage for the rest of his or her life in the event of your death if both of you elect coverage when you retire. If you are ineligible for Medicare when you retire, you will be covered by the UVa Health Plan until you become Medicare eligible.

If you are a retiree eligible for Medicare, the state insurance program is available to you as secondary coverage after Medicare.

Payment of Retiree Coverage Premiums/Self Payments

Once you enroll in retiree coverage under the Plan, you become responsible for the monthly premium payments. You can elect to have the premium debited directly from your VRS annuity or a personal account, or you can elect to receive coupons for monthly premium payments. The coupons will include the amount to be paid and the date on which the self-payments will be due. Coverage will not be provided if self-payments are not received, in full, when due. No claims will be paid for any medical expenses incurred by a person during any period for which self-payments have not been received. Reimbursements for covered expenses incurred will only be made when all required self-payments have been received.
Self-payments will be due on the first day of each month. Failure of self-payments to be received within 30 days of the due date shall result in cancellation of coverage with no option to reinstate coverage. If your premium is received after the due date but before the end of the 30 day grace period, your coverage under the plan will be suspended as of the first day of the coverage period (the due date), and then retroactively reinstated (going back to the first day of the coverage period) when the premium is received. This means that any claim you submit for benefits while your coverage is suspended may be denied, and may have to be resubmitted once your coverage is reinstated.

**Plan Changes/Self-Payment Amounts**
Should the Plan available to active Employees and/or Dependents change after you begin paying for retiree coverage, the Plan change shall also apply to you and your covered dependents.

The self-payment rates charged for the Retiree group and the benefits provided under the Plan are subject to change annually. Self-payment rates and benefits will generally not change more than once per year.

**Making Changes to Your Retiree Coverage**
You will be permitted to decrease your enrollment at any time. The change will be effective the first of the month following receipt of the application by the University Human Resources Benefits Division.

While you are a retiree in the UVA Health Plan, you can add eligible dependents to your coverage during any Open Enrollment period (while coverage remains in force) in the same manner as any Active Employee. Once you become eligible for Medicare and the state’s Medicare Supplement, changes are governed by the terms of those plans.

In addition, while a retiree in the UVA Health Plan, you may make changes to your benefit election during the Plan Year if you experience a Mid-Year Qualifying Event. These include:

- Marriage, Divorce, or Annulment;
- Birth or adoption/placement for adoption;
- Employment status of Enrollee, dependent, or spouse which affects eligibility to participate in the UVa Health Plan;
- Dependent satisfies or ceases to satisfy eligibility requirements;
- Judgment, decree or order changing legal custody;
- Cost and/or coverage changes in retiree’s, dependent’s, or spouse’s health plans;
- Entitlement to or loss of eligibility for Government-sponsored programs; or
- Death of spouse or dependent.

You must complete an enrollment application and return it to the University Human Resources Benefits Division within 31 days of the date of the event in order for coverage to be effective. Documentation that substantiates the Mid-Year Qualifying Event must accompany the application.
Most changes to coverage due to a Mid-Year Qualifying Event will be effective the first of the month following receipt of the application at the University Human Resources Benefits Division.

However, changes to coverage due to birth or adoption of a child are effective the first of the month in which the birth or adoption takes place, provided the application is received by the University Human Resources Benefits Division within 31 days of the event.

Complete details are available at the University Human Resources Benefits Division.

**IF YOU NEED EMERGENCY CARE OR NEED URGENT CARE WHILE TRAVELING OUT OF AREA**

If you have a medical emergency, the rules for receiving the higher level of benefits are suspended, as long as you have a true medical emergency, as determined by the Claims Administrator.

The emergency must be a sudden, unexpected onset of a medical or psychological condition with severe symptoms that could result in serious harm to you if left untreated. Examples of conditions that require emergency room treatment include, but are not limited to:

- Severe or unusual bleeding;
- Trouble breathing;
- Suspected poisoning;
- Prolonged or repeated seizures;
- Unconsciousness; or
- Severe burns.

If you get sick while traveling but do not need to visit the emergency room, you may visit an urgent care center for treatment and receive In-Network coverage. In order for the Claims Administrator to approve your visit, you:

- Must be traveling outside the network service area;
- Could not reasonably be expected to return to the network service area for treatment;
- Received care that could not have been anticipated before leaving the service area; and
- Are encouraged to contact the Claims Administrator within 48 hours or the next business day to notify them of urgent care treatment at urgent care facility or physician office.

**What You Need to Do**

- If you have a medical emergency, go immediately to the nearest appropriate medical facility.
- If you are admitted to the hospital, or need outpatient surgery to resolve the emergency, contact the Claims Administrator to notify them of your admission. If you are unable to make the call, have a family member, friend or the hospital call for you. Be sure the Out-of-Network provider requests and receives In-Network authorization for outpatient surgery if you are medically unable to return home.
If you visit an Urgent Care Center or physician office for urgent care, contact the Claims Administrator within 48 hours or the next business day.

Any follow-up treatment (care received after discharge from the emergency or urgent care medical facility or hospital admission through the emergency room) resulting from an emergency must be provided by a Participating Provider or Preauthorized by calling the Claims Administrator in order to receive In-Network benefits.

If You or a Dependent Move Away From the Area for More Than 90 Days

Members who will be residing outside of the Southern Health network service area for more than 90 days must enroll in the National Network and use the participating providers of the national network, in addition to the Southern Health network, when available in order to receive the highest level of benefits and pay the lowest cost-sharing amounts. This applies to all Out-of-Area participants, including retirees, COBRA enrollees and dependents who are away or at school. Members who reside outside of the United States or who do not have access to sufficient providers in the national network will be Out-of-Area enrollees, and will not be required to use the national network. To enroll in the National Network or Out-of-Area, you must complete an UVA Health Plan Out-of-Area form and submit it to the University Human Resources Benefits Division before the desired start date. The member will remain in this network until the end date documented on the form. The member needs to contact the University Human Resources Benefits Division to change the date originally submitted on the form. (e.g. subscriber or dependent moves back to the area.) For more information about the National Network and Out-of-Area enrollment, see “Points to Consider” on the enrollment form, which is available at University Human Resource Benefits Division website. Please refer to Important Guidelines for the National Network on Pages 102 and 103.
Continuation of Benefits (COBRA)

FAST FACTS

- You and your dependents may continue your coverage under the Plan through a federal law known as COBRA if your coverage ends due to certain Qualifying Events.
- Your children are eligible to continue coverage under COBRA when they no longer meet the Plan’s definition of “eligible dependent” as defined in the “Eligibility” section.
- Your spouse and children are eligible to continue coverage under COBRA when you become divorced.
- To keep your coverage under COBRA, you must make monthly payments to the COBRA Administrator on time. You will be fully responsible for the payment of your COBRA continuation coverage. Although you have a grace period to pay your premiums, claims will be suspended until payment is received.

What You Need to Do

Notify the University Human Resources Benefits Division immediately if you or your covered dependents experience a Qualifying Event. You have 60 days from the date of the event to contact the University Human Resources Benefits Division to enroll for COBRA. If you do not report the qualifying event during this timeframe, you will lose your eligibility to continue coverage under COBRA.

QUALIFYING EVENTS

Under a federal law called the “Consolidated Omnibus Budget Reconciliation Act” (COBRA), you and your eligible covered dependents may continue your group health benefits under the Plan when your coverage is lost due to a “Qualifying Event.” You and your spouse and/or dependent children must apply for coverage under COBRA following the Qualifying Event. Then, you must make monthly payments in order to keep your coverage.

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Who May Purchase Continuation Coverage</th>
<th>Duration of Continuation Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment terminates</td>
<td>You, your spouse and your dependent children who were covered under the Plan when coverage was lost</td>
<td>18 months</td>
</tr>
<tr>
<td>Your working hours are reduced, i.e., you become a part-time Employee</td>
<td>You, your spouse and your dependent children who were covered under the Plan when your status changed</td>
<td>18 months</td>
</tr>
<tr>
<td>You experience a termination or reduction in hours while you are disabled (as determined by the Social Security Administration)</td>
<td>You, your spouse and your dependent children</td>
<td>29 months (18 months plus an additional 11 months)</td>
</tr>
<tr>
<td>You divorce, or your marriage is annulled</td>
<td>Your spouse and your dependent children who were covered under the Plan at the time of divorce, marriage or annulment</td>
<td>36 months</td>
</tr>
<tr>
<td>Your dependent child no longer qualifies as a dependent</td>
<td>Your dependent child</td>
<td>36 months</td>
</tr>
<tr>
<td>You die</td>
<td>Your spouse and your dependent children who were covered under the Plan at the time of your death</td>
<td>36 months</td>
</tr>
</tbody>
</table>
WHEN COBRA CONTINUATION COVERAGE ENDS

Once COBRA coverage has been elected, it may be cut short on the occurrence of any of the following events:

• The first day of the time period for which you don’t pay the COBRA premiums within the required time period.

• The date any person receiving Continuation of Benefits coverage becomes covered under another group plan (as an Employee or otherwise, including as a spouse or dependent).

However, if a person has a medical condition that would be excluded from coverage as a result of a pre-existing condition by the other group plan, such person may continue to maintain Continuation of Benefits under this Plan, at the same self-payment contribution rate, but coverage under this Plan will be limited only to expenses that the Plan is required to cover according to federal law and regulations.

In such cases, it shall be the responsibility of the person to provide whatever information deemed necessary by the COBRA Administrator to determine the coverage limitations of the other group plan. Failure to provide such information shall result in the termination of the person’s coverage under this Plan. If, however, the Health Insurance Portability and Accountability Act of 1996 nullifies the pre-existing condition exclusion of another group health plan, then COBRA Continuation of Benefits under this Plan will cease on the last day of the month in which the person attains coverage for such pre-existing condition under another group health plan.

• The date you or your dependent becomes entitled to Medicare Part A or Part B or both.

• The date the Employer no longer provides health benefits to any of its Employees.

• The date the you or your dependent has been covered for the maximum Coverage Period as set forth below.

COVERAGE PERIOD

You may continue your coverage and/or the coverage for your dependents for a maximum of 18 months (except as noted below for persons who are totally disabled). Dependents who would otherwise lose coverage for one of the reasons listed above in the paragraph titled “Qualifying Event” may continue coverage for a maximum of 36 months. If a dependent has a second qualifying event while continuing his coverage as a result of your termination or change in employment, then the maximum period is measured from the first qualifying event that applied to the dependent.

Coverage Extension Rules for Disabled Persons

If an individual covered under Continuation of Benefits, whose maximum period of coverage would otherwise be limited to 18 months, is determined by the Social Security Administration while under COBRA (Continuation of Benefits) coverage to have been totally disabled at the time of employment termination or reduction in hours, then under the following conditions, the individual shall be permitted to extend the maximum period of Continuation of Benefits to a maximum of 29 months:
• The individual must notify the COBRA Administrator in writing within 60 days after the determination of total disability was made, and before the original 18-month coverage period ends. Proof of the disability must be provided within that same time period;

• The self-payment amount that will be charged to the individual for each month of coverage beyond the 18th month will be up to 150% of the self-payment amount charged to all other individuals who are on Continuation of Benefits, but who are not totally disabled;

• Should an individual on Extension of Continuation of Benefits recover from his or her disability to the extent that such individual is no longer totally disabled, as defined below, Continuation of Benefits shall be terminated as of the first day of the month following a 30-day period from the date the individual is no longer totally disabled;

• The term “totally disabled” with respect to this Section shall mean that the individual has been determined by the Social Security Administration to be entitled to receive Social Security Disability Benefits under Title II or XVI of the Social Security Act.

### Notification Requirements

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Notification Procedures</th>
<th>Who Must Take Action and When</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you terminate employment</td>
<td>The COBRA Administrator will send a COBRA notification letter to your last known address notifying you and your dependents of your right to continued coverage</td>
<td>You must send a written request for COBRA to the COBRA Administrator within 60 days of the date of the letter of Notification or the date of your employment termination, or the date that Plan coverage would otherwise be lost, if later</td>
</tr>
<tr>
<td>If you die while an active Employee</td>
<td>The COBRA Administrator will send a COBRA notification letter to the last known address of your covered spouse or other applicable dependent. Notification to your spouse will constitute notification to all eligible dependent children</td>
<td>Your spouse or eligible dependent children must send a written request for COBRA to the COBRA Administrator within 60 days of the date of the letter of Notification</td>
</tr>
<tr>
<td>Other qualifying events</td>
<td>The covered employee or qualified beneficiary must notify the University Human Resources Benefits Division of certain qualifying events. Those events are: Employee’s divorce or child’s loss of dependent status under the Plan’s terms</td>
<td>You must notify the University Human Resources Benefits Division within 60 days of the date of the qualifying event</td>
</tr>
<tr>
<td>Specific Notice</td>
<td>The COBRA Administrator will send a COBRA notification letter to the last known address of your ex-spouse in the case of divorce or your address for a child’s loss of eligibility</td>
<td>The ex-spouse or ineligible dependent must elect COBRA within 60 days of the qualifying event (such as the date of divorce or the date of loss of dependent eligibility) or the date of the letter of Notification, or the date that Plan coverage would be otherwise lost, if later</td>
</tr>
<tr>
<td>If you seek an extension of COBRA coverage due to disability</td>
<td>You must notify the COBRA Administrator</td>
<td>Within 60 days of any final determination by the Social Security Administration the individual is no longer disabled and within 18 months of the qualifying event</td>
</tr>
</tbody>
</table>
**What happens if I miss paying my COBRA premium?**

Failure to make self-payments for COBRA coverage within 30 days of the due date shall result in cancellation of your coverage with no option to reinstate it.

**How to Elect COBRA Coverage**

You must make a written request to continue benefits under COBRA. A written request must be received within 60 days of the date of the letter of Notification or the date of the Qualifying Event, if later. You should review the letter of Notification you receive (if any) from the COBRA Administrator regarding the amount of self-payment to be paid and when the first and subsequent self-payments will be due. No additional notices will be sent.

**Cost of Coverage**

The amount of self-payment to be paid by the covered person shall be 102% of the applicable premium (total cost of Plan coverage for a Participant), in accordance with procedures permitted by applicable law. Coverage will not be provided if self-payments are not made, in full, when due. No claims will be paid for any medical expenses incurred by a person during any period for which self-payments have not been made. Reimbursements for covered expenses incurred will only be made when all required self-payments have been made.

Once you elect COBRA, the premium payment for the initial period of COBRA coverage must be paid within 45 days of the date of election. If this initial premium is not paid on time or does not include all retroactive self-payments due, you will not be entitled to any period of continued coverage.

On an ongoing basis, premium payments are due on the first day of the month for which coverage is sought (the coverage period). If any payment due is not received within 30 days of the due date, coverage will end. If your premium is received after the due date but before the end of the 30 day grace period, your coverage under the plan will be suspended as of the first day of the coverage period, and then retroactively reinstated (going back to the first day of the coverage period) when the premium is received. This means that any claim you submit for benefits while your coverage is suspended may be denied, and may have to be resubmitted once your coverage is reinstated.

**Plan Changes/Self-Payment Amounts**

Should the Plan available to active Employees and/or Dependents change after you begin paying for COBRA coverage, the change in Benefits shall also apply to you and your covered dependents.

The self-payment rates charged for the COBRA group and the benefits provided under the Plan are subject to change annually. Self-payment COBRA rates and benefits will generally not change more than once per year.

**Address Changes**

In order to protect your family’s rights, you should keep the COBRA Administrator informed of any changes in addresses of family members.

**Plan Contact Information**

COBRA coverage is available through the University of Virginia Health Plan. Contact the University Human Resources Benefits Division at 434-924-4392, 914 Emmet Street, P.O. Box 400127, Charlottesville, VA 22904-4127 for additional information about COBRA continuation coverage.
MAKING CHANGES TO YOUR COBRA COVERAGE

You will be permitted to decrease your enrollment at any time (i.e., drop the number of dependents covered). The change you make will be effective the first of the month following receipt of your application by the University Human Resources Benefits Division. You can add eligible dependents to your coverage during any Open Enrollment period (while coverage remains in force) in the same manner as any Active Employee.

In addition, you may make changes to your benefit election during the Plan Year if you experience a Mid-Year Qualifying Event. These include:

- Marriage, Divorce, or Annulment;
- Birth or adoption/placement for adoption;
- Employment status of Enrollee, dependent, or spouse which affects eligibility to participate in the Health Plan;
- Dependent satisfies or ceases to satisfy eligibility requirements;
- Judgment, decree or order changing legal custody;
- Cost and/or coverage changes in employee’s, dependent’s, or spouse’s health plans;
- Entitlement to or loss of eligibility for Government-sponsored programs;
- Death of spouse or dependent.

You must complete an change application and return it to the University Human Resources Benefits Division within 31 days of the date of the event in order for coverage to be effective. You must provide documentation that substantiates the Mid-Year Qualifying Event change with your enrollment application.

Most changes due to a Mid-Year Qualifying Event will be effective the first of the month following receipt of the application at the University Human Resources Benefits Division.

NOTE: Changes to coverage due to birth or adoption of a child or ineligibility of a dependent due to age or marriage are effective the first of the month in which the birth or adoption takes place or the first of the month following the ineligibility event, provided the application is received within 31 days of the event.

Complete details are available at the University Human Resources Benefits Division.

NOTE: All changes to enrollment as a COBRA enrollee must be submitted within 31 days instead of the 60 days as stated in this document for Active Employees.

This Section will be administered in accordance with the applicable provisions of the Internal Revenue Code.
How the Plan Works

FAST FACTS

• The UVa Health Plan offers two different Direct Access Health Programs for Plan Participants:
  – the High Premium Program; and
  – the Low Premium Program.

• The Plan also provides coverage for those who live outside the areas served by the Claims Administrator's Provider Network through enrollment in the National Network, a national Preferred Provider Organization; and an Out-of-Area program option for those who require coverage out of the country or outside areas served by either the Claims Administrator's Provider Network or the National Network.

Guidelines for members in the National Network may be found at the back of this document. For National Network or Out-of-Area coverage, you must meet certain requirements in order to be eligible for this coverage—it is not automatic. Contact the University Human Resources Benefits Division for more information and to enroll.

• The Claims Administrator is the same for both the High Premium Program and the Low Premium Program. This means that the provider network for both the High Premium and the Low Premium Programs is the same.

• The UVa Health Plan has Preauthorization requirements for certain procedures in order to determine the Medical Necessity of a service. These requirements apply to both the High Premium and Low Premium Programs.

• Both the High and Low Premium Programs allow you direct access to physicians and specialists at all times. In other words, you do not have to select a Primary Care Physician (PCP), although a relationship with a Primary Care Provider is encouraged. You may go directly to any physician or specialist you wish (either In-Network or Out-of-Network). You receive a higher reimbursement amount when you use Network Providers; you will have significant out-of-pocket costs if you use Out-of-Network providers.

**High Premium Program vs. Low Premium Program**
The UVa Health Plan offers you a choice between two programs—A High Premium Program and a Low Premium Program. Both programs offer similar benefits and the same network of providers, but the way benefits are paid and your share of the cost is different.

*The High Premium Program*
The High Premium Program consists of a network of providers (In-Network providers). Whenever you’re in need of treatment, you have the option of visiting an In-Network provider or an Out-of-Network provider.
Some features of the High Premium Program:

- Higher monthly contributions than the Low Premium Program are required.
- It’s not necessary to meet an annual Deductible when you visit an In-Network provider.
- In-Network Preventive diagnostic, laboratory and radiology procedures are covered in full. Preventive services must be obtained from a primary care physician provider.
- Prenatal diagnostic tests, laboratory services, and radiologic procedures are always covered at 100% when provided by In-Network providers.
- Mammograms and PSAs are always covered at 100% when provided by In-Network providers; the Plan pays 90% of the Allowable amount for most other In-Network diagnostic services.
- Most other In-Network services are paid in full after you pay a Copayment.
- Coinsurance applies to Out-of-Network services. Your Coinsurance for most Out-of-Network services is 25% of the Allowable Amount after you have met your Deductible. There are also amounts above the Allowable Amount that you will owe Out-of-Network providers.

The Low Premium Program
The Low Premium Program also consists of a network of providers (In-Network providers). Whenever you’re in need of treatment, you have the option of visiting an In-Network provider or an Out-of-Network provider.

Some features of the Low Premium Program:

- Lower monthly contributions than the High Premium Program are required.
- You must meet an annual Deductible when you visit an In-Network provider and an Out-of-Network provider.
- In-Network Preventive diagnostic, laboratory and radiology procedures are covered in full. Preventive services must be obtained from a primary care physician provider.
- Prenatal diagnostic tests, laboratory services, and radiologic procedures are always covered at 100% when provided by In-Network providers.
- The Plan pays 80% of the Allowable Amount for most covered In-Network services.
- Coinsurance applies to Out-of-Network services. Your Coinsurance for most Out-of-Network services is 40% of the Allowable Amount after you have met your Deductible. There are also amounts above the Allowable Amount that you will owe Out-of-Network providers.

What You Need to Do

- During enrollment, carefully compare the High Premium and Low Premium Programs and the amount of reimbursement the programs offer in order to choose the program that best suits your needs. Refer to the Schedule of Benefits to compare the benefit levels of both programs.
- You must follow the Preauthorization requirements of the program you elect in order to obtain the highest level of benefits.
PAYING FOR SERVICES

The cost for medical services is paid at what’s called the “Allowable Amount.” This is a rate that the Claims Administrator has negotiated with the In-Network Providers for covered services. In-Network Providers, or participating providers, accept the Allowable Amount as payment in full for services, even if their actual charge is higher.

Preventive care and immunizations are not covered when you use Out-of-Network Providers. In addition, most Out-of-Network care requires you to obtain Preauthorization. Refer to page 41 for details on the Plan’s Preauthorization requirements.

Your financial responsibility for medical services depends on the service you receive and whether or not you visit a provider who participates in the network. In addition to your premium payments, your share of the responsibility includes:

- Your annual Deductible;
- Your Copayment;
- Your Coinsurance;
- Amounts more than the “Allowable Amount” when you visit an Out-of-Network provider; and
- Amounts after you’ve exceeded the Lifetime Maximum.

The Annual Deductible
The annual Deductible is the dollar amount of covered services that you must pay before the plan begins to pay benefits each calendar year. The Deductible does not apply to the doctor’s office visit Copayments if you use a Network provider. In addition, Copayments don’t count toward satisfying your Deductible or Out-of-Pocket Maximum for coinsurance.

High Premium Program
If you participate in the High Premium Program, the annual Deductible only applies if you visit an Out-of-Network provider. You do not have to satisfy a Deductible if you receive care In-Network.

Low Premium Program
In the Low Premium Program, you must meet an annual Deductible before the Plan will pay benefits for services incurred both In- and Out-of-Network. However, the Deductible is lower when you use a Network provider.

Expenses that Do Not Apply Toward Satisfying the Annual Deductible

- Charges above the Allowable Amount;
- Copayments for Network office visits; and
- Charges for services not considered Medically Necessary and not covered by the Plan.
Copayments
For certain services, you pay a fixed amount, called a “Copayment.” The amount you pay depends on the service. Copayments are necessary for the services listed below when you visit a Network Provider:

- Office visits;
- Specialist visits and first maternity visit;
- Urgent care visits;
- Outpatient mental health;
- Speech, physical and occupational therapy visits; and
- Chiropractic care.

Coinsurance
Your Coinsurance is the percentage of the Allowable Amount that you pay for a particular service.

The High Premium Program
Under the High Premium Program, most In-Network services are paid in full after you pay a Copayment. There is a 10% coinsurance for diagnostic services provided by In-Network providers. For Out-of-Network Providers the High Premium Program pays 75% of the Allowable Amount and you pay 25%, after you’ve met your Deductible, plus amounts above the Allowable Amount.

The Low Premium Program
The Low Premium Program pays 80% of the Allowable Amount for most covered In-Network services and your Coinsurance is 20% after you’ve met your deductible. For Out-of-Network services, the Low Premium Program pays 60% of the Allowable Amount and your Coinsurance is 40% after you’ve met your Deductible, plus amounts above the Allowable Amount.

Amount More than the Allowable Amount (Out-of-Network Only)
When you visit an Out-of-Network provider, the plan still pays benefits at the Allowable Amount rate, but Out-of-Network providers are not required to accept this rate as payment in full. Therefore, if you visit an Out-of-Network provider and you are charged more than the Allowable Amount, you’ll be responsible for paying the difference, which can be significant. It is recommended that member contact Southern Health Customer Service before receiving Out of Network services to calculate difference between allowable amounts and provider charges for a specific procedure code in an outpatient or inpatient setting. Amounts above Allowable can be substantial and some allowable amounts may be capped.
The example below shows what you would pay for Out-of-Network services in the High Premium Program. To simplify the example, let’s assume that the Out-of-Network Deductible has been met.

<table>
<thead>
<tr>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td>Physician’s Charge</td>
</tr>
<tr>
<td>Allowable Amount</td>
</tr>
<tr>
<td>Plan Pays</td>
</tr>
<tr>
<td>OON Deductible</td>
</tr>
<tr>
<td>Amount paid to provider by plan</td>
</tr>
<tr>
<td>You Pay</td>
</tr>
</tbody>
</table>

$925 Member total

The Lifetime Maximum
The Plan will only pay or reimburse for charges for Covered Medical Services that are considered Medically Necessary, up to a Lifetime Maximum of $2,000,000 per covered person. After you meet the $2,000,000 maximum, you are responsible for 100% of costs for your medical services.

Annual Maximum Out-of-Pocket Expense For Coinsurance
The annual out-of-pocket expense may limit the amount you have to pay for eligible expenses each year. Your Coinsurance has an annual maximum out-of-pocket expense—your Deductible and Copayments for In-Network office visits do not. After you reach this maximum, the Plan pays 100% of the Allowable Amount for any other eligible expenses that require coinsurance that year. You can accumulate this maximum with any combination of eligible expenses you and your covered dependents have (either an individual has to meet the individual out-of-pocket maximum or the family must meet the family maximum before the plan pays at 100%). Refer to the schedule of benefits on page 7 for out-of-pocket maximum amounts.

Expenses that Do Not Apply Toward Your Out-of-Pocket Maximum For Coinsurance

- Charges above the Allowable Amount continue to be your responsibility, even after you reach your out-of-pocket maximum;
- The Copayment for Network office visits; and
- Charges for services not considered Medically Necessary and not covered by the Plan.
Are there different Preauthorization rules for Mental Health and Substance Abuse, Prescription Drug and Dental Care?

Yes. Refer to each of these sections for details on the Preauthorization procedures that the Claims Administrators of these benefits have in place.

Medically Necessary Covered Services

The Plan will only cover services that are considered “Medically Necessary.” The Plan does not cover all medically necessary services. The Claims Administrator’s medical director(s) determines the Medical Necessity of Covered Medical Services for care or supplies that are:

- Considered good medical practice and appropriate for the diagnosis or treatment of a covered medical condition;
- Provided by a licensed provider in a hospital or other facility described here;
- Required for a reason other than improving physical appearance;
- Not for the convenience of the patient or provider; and
- The most cost-effective and appropriate supply, location, or level of service available that can safely be provided.

The Plan’s Preauthorization Rules

In order to determine medical necessity, the Plan requires Preauthorization for certain procedures, including most Out-of-Network Services, whether you participate in the Low or High Premium Program.

If you use Southern Health Network Providers, generally that provider is responsible for obtaining Preauthorization for covered services.

You are responsible for obtaining Preauthorization if you use National Network or Out-of-Network Providers. Refer to the chart below, “Who is Responsible for Preauthorization” for details. Failure to obtain Preauthorization for services that require it will result in a denied claim.

If you obtain Covered Medical Services through a National Network or Out-of-Network Physician and the services are not approved in advance by the Claims Administrator, the Claims Administrator will review your claim for payment and will not pay for services that are not determined Medically Necessary. Your Out-of-Network provider can then bill you for those fees that the Plan will not pay—this is why it’s extremely important for you to obtain Preauthorization for Out-of-Network procedures, so you will know up front how the Plan will cover your procedures and if you will be responsible for additional expenses.

Preauthorization Requirements if You Go Out-of-Network or Are a National Network member using National Network Providers

The Preauthorization requirements, listed below, apply if you decide to use Out-of-Network Providers or if you are a National Network member using National Network providers.

- You must contact the Claims Administrator before admission to an Out-of-Network facility or if your Out-of-Network Physician is admitting you to the hospital for an elective procedure (whether the hospital is In-Network or Out-of-Network).
• For emergency admissions when you are under the care of an Out-of-Network Physician, you must contact the Claims Administrator within 48 hours of the admission. The Claims Administrator will determine whether or not it will approve payment for the admission.

  – If the Claims Administrator does not approve the admission and you are admitted anyway, the Claims Administrator will review your claim for payment and, if it is determined that any portion of the care was Medically Necessary, the Plan will cover only that portion of care.

• For maternity hospital admissions at an Out-of-Network facility, or for the delivery of your baby by an Out-of-Network provider, you must contact the Claims Administrator as soon as you know the estimated date of delivery.

Certain medical procedures, supplies and equipment must be Preauthorized to determine whether or not the Plan will cover them. The list of services requiring Preauthorization is below.

**Medical Services that Require Preauthorization**

Both the High and Low Premium Programs require the Claims Administrator to Preauthorize all inpatient admissions and certain outpatient services and elective procedures, including:

• Automatic Internal Cardiac Defibrillator (AICD)

• Behavioral health and substance abuse services: inpatient or outpatient behavioral health services or substance abuse treatment or rehabilitation*

• Bi-ventricular pacemaker

• Cardiac rehabilitation

• CT scans

• Dental treatment for Dental Accidents

• DEXA scans received by members under the age of 60 (e.g. Bone Scans)

• Durable Medical Equipment (DME): purchase of DME costing over $250, (except ostomy supplies) and all rentals of DME

• Genetic testing and genetic counseling

• Home health care (nursing, infusion, respiratory, etc.)

• Hospital Observation Stays

• Injectable and Self-Administered Injectable Drugs, if Covered under Medical and Surgical Benefits Instead of Prescription Drug Benefits

• Inpatient Hospital Care, including Inpatient Hospice

• Insulin Pumps and Supplies

• Intensity-Modulated Radiation Therapy

• Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiogram (MRA)/Positive Emission Tomography (PET scan)

• Non-emergency Ambulance Transportation

• Nonimplanted Prosthetic Devices
• Nuclear Imaging Performed in Conjunction with Exercise Stress Testing
• Outpatient Surgery (Hospital or Freestanding Surgical Center)
• Pain Management Services/Program, including Epidural Steroid Injections
• Polysomnograms (Sleep Apnea Studies)
• Prenatal Notification Only
• Psychological or Neuropsychological Testing
• Pulmonary Rehabilitation
• Rehabilitative Services and Physical, Occupational, or Speech Therapy Received Inpatient or Outpatient
• Services Related to Identifying the Cause of Infertility
• Skilled Nursing Facility Care
• Transplant Consultations, Evaluations, and Testing/Transplant Procedures

This list is subject to change. Please call Customer Service for the most current list.

* Preauthorization must be requested from the contracted mental health vendor which is listed on the back of the member ID card.

Who is Responsible for Preauthorization

<table>
<thead>
<tr>
<th>If You Access Care Through</th>
<th>Who Initiates the Call</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>High or Low Premium Program Southern Health In-Network Provider</td>
<td>Your Network Provider</td>
<td>By calling the Claims Administrator at the number on your ID card</td>
</tr>
<tr>
<td>High or Low Premium Program Out-of-Network Provider</td>
<td>You</td>
<td>By calling the Claims Administrator at the number on your ID card</td>
</tr>
<tr>
<td>National Network In-Network Provider</td>
<td>You</td>
<td>By calling the Claims Administrator at the number on your ID card</td>
</tr>
<tr>
<td>National Network Out-of-Network Provider</td>
<td>You</td>
<td>By calling the Claims Administrator at the number on your ID card</td>
</tr>
<tr>
<td>Out of Area</td>
<td>You</td>
<td>By calling the Claims Administrator at the number on the back of your ID card</td>
</tr>
</tbody>
</table>

If you have questions about Preauthorization, please contact the Claims Administrator by calling the number on the back of your ID card.
Physician Office Visit and Outpatient Coverage

FAST FACTS
The Plan covers Medically Necessary:

- Preventive health services;
- Diagnosis and treatment of disease or injury or other conditions as well as testing and laboratory services;
- Therapy including physical, occupational, speech/aural, radiation and chemotherapy;
- Certain medications administered in the physician’s office;
- Obstetrical services;
- Allergy testing and treatment;
- Diabetic counseling;
- Second opinions;
- Spinal manipulations;
- Elective sterilization; and
- Early intervention services for certain developmentally disabled children from birth to age three, who meet certain requirements.

What You Need to Do

- Call the Claims Administrator to Preauthorize all hospital admissions and surgeries, or if you have a question about what the Plan covers.
- Be aware of Plan exclusions listed at the back of the book.
- Call the Claims Administrator to determine if the medication to be given in the physician’s office needs to be obtained through the Prescription Drug Plan.

YOUR COVERAGE

The Claims Administrator, on behalf of UVa, will pay or reimburse for the Medically Necessary services described in this Section when they are performed or ordered by a Designated Provider. These services are the “Covered Medical Services” under the Plan. Your costs for these services will depend on whether you obtain services through the High Premium Program or the Low Premium Program and whether or not the provider is a network provider.

You are entitled to Benefits for the following services at a physician’s office and/or the outpatient department of the hospital. Physician office visit Copayments, a Deductible, Coinsurance or amounts above the Allowable Amount may apply depending on how care is obtained. Some of these Benefits may have additional limitations. Refer to the Schedule of Benefits for details on how the Plan pays for covered services. Or, call the Claims Administrator if you have questions.
Preventive Health Services

- Physical examinations (including pap tests and mammograms) provided by a Network Physician under the High Premium and Low Premium Programs.
- Well-baby care provided by a Network Physician under the High and Low Premium Programs, including routine infant hearing screenings and necessary audiological examinations as prescribed for newborn children, including any follow-up audiological examinations recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.
- Clinical laboratory and radiological tests and immunizations.
- You can access these Preventive Health Guidelines on the Claims Administrator’s website (www.southernhealth.com) or you may request that the Claims Administrator send you these guidelines.

Diagnosis and Treatment

- Services of physicians and other medical personnel for the diagnosis and treatment of disease, injury, or other conditions; and
- Emergency and urgent care, which are Medically Necessary. This includes surgical procedures performed in a physician’s office and consultations with specialists.

Imaging and Laboratory Services

Imaging and laboratory tests and services when ordered by a physician.* This includes:

- Prescribed diagnostic imaging;
- X-ray therapy;
- Electrocardiograms;
- Laboratory tests; and
- Diagnostic clinical isotope services.

Refer to the list of services that require Preauthorization in the Section titled “How the Plan Works.”

* Refer to Plan Exclusions

Physical/Occupational Therapy

- Medically Necessary short-term physical or occupational therapy services, up to the maximum indicated in the Schedule of Benefits.
- Short-term is defined as therapy that must be restorative in nature and must be expected to produce significant improvement.
- Physical and occupational therapy for developmental delay/motor problems whose etiology is developmental is not a covered benefit.
- Physical and occupational therapy services provided by a chiropractor licensed to provide therapy will apply toward the maximum number of physical and occupational therapy visits as indicated in the Schedule of Benefits.
• Preauthorization by the Claims Administrator is required for coverage of physical and occupational therapy.

**Speech/Aural Therapy**

• Medically Necessary short-term speech or aural therapy to meet the functional needs of a Participant suffering from physical impairment due to illness, injury, or trauma up to the maximum indicated in the Schedule of Benefits.

• Short-term is defined as therapy that must be restorative in nature and must be expected to produce significant improvement.

• Speech therapy provided for developmental delay disorders, motor problems whose etiology is developmental, or learning disabilities is not a covered benefit.

• Preauthorization by the Claims Administrator is required for speech/aural therapy.

**Radiation Therapy and Chemotherapy**

The Plan covers radiation therapy and chemotherapy. See Prescription Drug section and check to see if the injectable/specialty medication must be obtained through the Prescription Drug Plan when given in a Physician’s Office.

**Medications for Use in the Physician’s Office**

Certain medications, radioactive materials, dressings, and casts, administered or applied by a physician or other provider in the physician’s office for preventive or therapeutic purposes. Injectable and specialty medications must be obtained through the Prescription Drug Plan if to be given in a Physician’s office.

**Obstetrical Services**

• The full range of obstetrical services, including prenatal visits and postpartum visits, and all of the other services set forth above, with respect to pregnancy.

• These covered services are in accordance with the medical criteria outlined in the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists, for the “Standards for Obstetric-Gynecologic Services,” which was prepared by the American College of Obstetricians and Gynecologists.

• A participating nurse midwife may provide obstetrical care. Obstetrical care does not include services for childbirth performed in the Participant’s house.

**Allergy Testing and Treatment**

Tests to determine the nature of allergies and desensitization treatments (“allergy shots”) to alleviate allergies, including test or treatment materials.

**Diabetic Counseling**

This coverage is provided if your Provider is:

- Legally authorized to prescribe such services under law; and
- A certified, registered, or licensed health care professional.

**Second Opinion**
If you request a second opinion, the Plan will provide coverage for a second opinion for proposed surgery or treatment under the following conditions:

- The second opinion is given by a physician who is a board-certified specialist and who, by reason of his or her specialty, is an appropriate physician to consider the surgical procedure or treatment; and
- The second opinion is rendered for a covered surgical procedure of a non-emergency nature; and the physician who gives the second opinion does not subsequently perform the surgery or provide the treatment for which the second opinion was obtained. If the physician who rendered the second opinion does perform the surgery or provide the treatment, he will be paid for the surgery or treatment, not the second opinion consultation.

**Spinal Manipulations**
Medically Necessary spinal manipulations are covered, up to the maximum indicated in the Schedule of Benefits.

**Elective Sterilization**
The full range of services with respect to male or female elective sterilization procedures are covered. Reversal of sterilization is not covered.

**Early Intervention Services**
The Plan offers special provisions for developmentally disabled children from birth to age three that qualify under the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. & 1471 et.al.).

Medically Necessary services that help an affected child attain or retain the ability to function age-appropriately are covered, such as:

- Speech and language therapy;
- Occupational therapy;
- Physical therapy;
- Assistive technology services; and
- Devices.

Coverage for these services is not applied toward the maximum lifetime benefit under the Plan and are limited to $5,000 per lifetime. Benefits and limits to the early intervention services are determined by the Commonwealth of Virginia as stated in the Virginia Code. Any Copayment, Coinsurance or Deductible required for these services may be paid through the use of Federal Part H program funds, state general funds, or local government funds appropriated to implement Part C services for families who may refuse the use of their health care coverage to pay for early intervention services due to their payment responsibility. Contact the Claims Administrator for details on this program.
Physician and Surgical Benefits

**FAST FACTS**

The Plan covers Medically Necessary:

- Surgery (including obstetrical care) and related care by the surgeon before and after the operation are covered;
- An assistant surgeon’s fee;
- Surgeons’ consultation fees;
- The fee for administering anesthesia;
- Physician’s visits while you are hospitalized; and
- Diagnostic testing, x-rays and other laboratory testing associated with the surgery.

**What You Need to Do**

- Ensure that Preauthorization procedures for all hospital admissions and surgeries are followed.
- Call the Claims Administrator if you have a question about what the Plan covers.
- Be aware of your costs for using Out-of-Network providers by contacting the Claims Administrator prior to receiving services.

**YOUR COVERAGE**

During any period of covered hospitalization, the following Medically Necessary services are covered.

**Surgery**

Surgery includes correction of fractures and dislocations, endoscopies, and any incision or puncture of the skin or tissue that requires the use of surgical instruments. The Benefit amount for the surgery includes payment for Medically Necessary related care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon’s care before and after the operation.

Payment for surgery is also subject to the following limitations:

- When more than one surgical procedure is performed at the same time, whether through one or more incisions, the Plan will pay for the major or first procedure. It will also pay one-half of the payment otherwise payable for the lesser or subsequent procedures; and
- When an incidental procedure, including but not limited to, incidental appendectomy, lysis of adhesions, incision of previous scar, or puncture of ovarian cyst is performed through the same incision, the Plan will pay for the major procedure only; and
- The total payment for an operative procedure that is performed in two or more steps is limited. The Claims Administrator will pay only the amount that would have been paid if the procedure were performed in one step.
Assistance at Surgery in a Hospital
The Claims Administrator determines and covers Medically Necessary assistance by another physician during the course of an operation.

Medical Visits in a Hospital
Medical visits by a Designated Provider while the Participant is a registered inpatient in a hospital. The medical visits are for care of illnesses or conditions other than those related to surgery or obstetrical care.

Separate Benefit payments for visits in connection with surgery or maternity care will not be made, because the amount of the payment for surgery or maternity care includes payment for such visits, except under the circumstances described in the paragraph immediately below.

Complications in a Hospital
Services of a second physician in a hospital when a Participant has an “exceptional complication” in surgery, maternity or inpatient hospital care. An “exceptional complication” is a condition that is not related to the condition for which the Participant was admitted to the hospital. It may also be a condition that is so unusual that it requires more than the customary surgical, maternity or medical care.

Anesthesia in a Hospital
A Designated Provider’s administration of anesthesia in connection with surgery or maternity care. No payment will be made if the provider who administers the anesthesia also performs the care, or assists the provider who performs the care, and receives payment for that care.

Consultations in a Hospital
Consultation by a participating physician who is called in by a Participant’s physician if both the following conditions are met: the consulting physician is a specialist in the Participant’s illness or disease; and the consultation takes place while the Participant is a registered inpatient in a hospital. Non-participating providers are covered at the Out-of-Network rate if Preauthorization is obtained.

Obstetrical Care
Inpatient medical services related to obstetrical delivery of a baby, complications of pregnancy, miscarriage, or abortion (to the extent covered by the Plan and indicated in the Section titled “Exclusions”). The amount of the payment for obstetrical care includes payment for all of the Medically Necessary care provided by the Designated Provider that is related to the pregnancy.

Newborn Care
Initial examination, nursery charges, and circumcision of a newborn child in a hospital is covered when the examination is performed by a Designated Provider other than the delivering physician and the child is enrolled in the Plan.

Newborn infant hearing screenings and all necessary audiological examinations provided in a participating hospital are covered. The screenings must use FDA approved technology that is recommended by the Joint Committee on Infant Hearing in its current position statement addressing early hearing detection and intervention programs. Follow up audiological
examinations as recommended by the infant’s physician or audiologist and performed by a participating licensed audiologist to confirm the absence of hearing loss are also covered.

**Diagnostic Imaging**
Medically Necessary diagnostic imaging performed by, or on the order of, a Designated Provider to diagnose a condition or illness for which the Participant showed symptoms.

**Radiation Services**
Medically Necessary radiation services performed by, or on the order of, a Designated Provider. The radiation services may include use of x-rays, radiation or radioactive isotopes.

**Laboratory Services**
Laboratory tests performed by, or ordered by, a Designated Provider.*

* Refer to Plan Exclusions for lab tests not covered.
FAST FACTS

The Plan covers Medically Necessary:

- Inpatient and outpatient care expenses in a hospital or Urgent Care Facility;
- Ambulance expenses; and
- Organ/tissue transplants.

In addition, the Plan provides case management services for serious health conditions.

What You Need to Do

- Ensure that your hospital admissions and urgent care are preauthorized through the Claims Administrator. Outpatient care in a hospital may need to be preauthorized in order for services to be covered by the Plan.
- Be aware of costs for Out-of-Network hospital care by contacting the Claims Administrator prior to receiving services for non-emergencies.

YOUR COVERAGE

During any period of covered hospitalization, the following Medically Necessary services are covered.

**Inpatient Care in a Hospital**
Benefits are available for services furnished by an acute care general hospital when you are a registered inpatient in such a hospital.

Covered Medical Services may include services provided by an acute care general hospital such as:

- Room and board;
- Nursing care;
- Medical social work;
- Pharmacy services and supplies;
- Diagnostic laboratory tests;
- Operating room charges; and
- Labor and delivery room charges.

**Outpatient Care in a Hospital**
The Plan will pay for the Covered Medical Services provided to a Participant in the outpatient department of a hospital, including the hospital emergency room, if equivalent services would also be covered on an inpatient basis. Preauthorization by the Claims Administrator is required for certain outpatient services listed in the Section titled “Preauthorization.”
The Plan will also pay the facility’s charges per the schedule of benefits for Covered Medical Services provided in a:

- Health center;
- Diagnostic center;
- Treatment center;
- Birthing center;
- Ambulatory surgical center; and
- Hemodialysis center.

In order for the Plan to cover expenses, the facility must possess all licenses, permits, certifications, and approvals required by applicable state, local, and federal law.

**Urgent Care Facility**

Visits to an Urgent Care Facility are paid like physician’s office visits according to the manner under which care is accessed. If you are in area or traveling out-of-area and have an accident or unforeseen illness or injury that requires immediate care, you may seek medical care at an Urgent Care Facility or nearest appropriate medical office or facility and In-Network Benefits will be provided for services meeting urgent care medical criteria. It is recommended that you notify the Claims Administrator within 48 hours or as soon as physically possible. Refer to the Schedule of Benefits for the applicable cost sharing amounts.

**Emergency Room Care**

If you visit an Emergency Room and have a true medical emergency as determined by the Claims Administrator, coverage is provided as defined in the Schedule of Benefits.

The emergency must be a sudden, unexpected onset of a medical or psychological condition with severe symptoms that could result in serious harm to you if left untreated. Examples of conditions that require emergency room treatment include, but are not limited to:

- Severe or unusual bleeding;
- Trouble breathing;
- Suspected poisoning;
- Prolonged or repeated seizures;
- Unconsciousness; or
- Severe burns.

If the Claims Administrator determines that the services provided in the Emergency Room were not for the treatment of a true medical emergency, the claim will be denied.

**What You Need to Do**

- If you have a medical emergency, go immediately to the nearest appropriate medical facility.
- If you are admitted to the hospital, or need outpatient surgery to resolve the emergency, contact the Claims Administrator to notify them of your admission. If you are unable to make
Preauthorization is required for coverage for transplants

Benefits will not be provided for any organ or tissue transplant procedures not specifically covered under the Plan, or for any transplants or investigative procedures that do not meet the established criteria determined by the Claims Administrator.

Ambulance Service
Covered Medical Services include a licensed ground or air ambulance that charges a fee for its services if:

- Because of an accident or medical emergency, it is necessary to transport the Participant to a local hospital in an ambulance;
- It is necessary to transport the Participant from a hospital where he is an inpatient to another hospital because: the first hospital lacks the equipment or expertise necessary to care for the Participant properly and the Participant is admitted as an inpatient to the other hospital; or the Participant is taken to another hospital to receive a test or service that is not available at the hospital where the Participant has been admitted, and the Participant returns after the test or service is completed;
- The Participant is transported directly from a hospital where he was an inpatient to a local skilled nursing facility where he is then admitted as a patient;
- For limited non-emergency services when preauthorized.

Transplant Benefits
The University of Virginia Health Plan uses a national transplant network that is contracted to perform specific transplant services. The Plan reserves the right to require you to obtain services from a contracted provider who may be outside the Service Area in order for the plan to cover eligible transplant expenses.

The Plan will pay for Covered Medical Services for transplants that are generally recognized, including cornea; heart; lung; heart-lung; liver; pancreas; kidney; and bone marrow.

Diagnostic Procedures
The Plan covers diagnostic or therapeutic procedures that are associated with Medically Necessary transplant surgery that is covered according to Medicare guidelines.

Hospital Care
Medically Necessary inpatient and outpatient care at a designated transplant center, including hospital, medical-surgical and other services related to the transplant, such as blood and blood products. A facility is “designated” when it appears on the Claims Administrator’s list of centers designated for the specific transplant being performed.

Organ Procurement
Tissue typing, surgical procedure, storage expense, and transportation costs directly related to the donation of an organ or other human tissue used in a covered transplant procedure. For
information about Coordination of Benefits with Benefits available to a donor under his or her health benefit plan, refer to the “Coordination of Benefits” section.

**Pre-Operative Care**
The pre-operative Benefit period begins five days prior to surgery. During that period, the Plan will pay for Medically Necessary hospital, medical/surgical and other services related to the transplant.

**Post-Operative Care**
The post-operative Benefit period begins on the day the transplant procedure takes place and extends for a period of one year from that date. Covered Medical Services include any Medically Necessary hospital, medical, laboratory, and other services related to the organ transplant, and prescription drugs.

**Limitations**
To the extent permitted by applicable law, reimbursement to a Participant under this Plan will be secondary to any and all governmental or institutional sources of funding that will offset the cost of Covered Medical Services.

**Case Management for Serious Health Conditions**
The Plan has a Case Management Program under which the Claims Administrator may identify and offer alternative Benefits not otherwise provided to Participants under this Plan ("Alternative Benefits"). This program is designed primarily for Participants for whom continuing acute or skilled care in an inpatient setting is Medically Necessary.

The Case Management Program is designed to make available Alternative Benefits for care and services recommended by a Participant’s physician and tailored to the Participant’s specific health needs in accordance with the Case Management Program’s criteria. A Participant has the right to accept or decline any Alternative Benefits the Claims Administrator identifies and offers on the Plan’s behalf.

If the Claims Administrator determines that Alternative Benefits should be provided to a Participant, the Claims Administrator, with the Plan’s approval, may offer to pay for those services by sending the Participant a letter explaining the offer and including detailed information.

Acceptance of Alternative Benefits is entirely voluntary; a Participant has the right to decide whether or not to accept them. If a Participant does not wish to accept the Alternative Benefits available under the Case Management Program, Benefits under the Plan will continue to be available at the levels stipulated in this Plan.
Skilled Nursing Facility, Home Health and Hospice Care

FAST FACTS

- The Plan covers Medically Necessary care in a skilled nursing facility, home health and hospice care.
- Hospice Care is covered when you are diagnosed with a Terminal Illness and have chosen to receive palliative care only.
- A terminal illness is a condition that has been diagnosed as terminal by a licensed physician and the medical prognosis is a life expectancy of six months or less.

What You Need to Do

- All skilled nursing facility, home health, and inpatient hospice must be preauthorized by the Claims Administrator.
- The plan provides case management to help terminally ill patients obtain the care they need. For more information, contact the Claims Administrator.

YOUR COVERAGE

The Plan provides benefits for the following Medically Necessary services, when the proper Preauthorization is obtained.

Care in a Skilled Nursing Facility or Rehabilitation Facility

Covered Medical Services include care in a skilled nursing facility or rehabilitation facility if daily skilled care is Medically Necessary for the care of your condition, illness or injury and confinement in a nursing facility is prescribed in lieu of hospitalization. Refer to the Schedule of Benefits for specific benefit information.

Preauthorization by the Claims Administrator is required. Respite, custodial rest cures, domiciliary, or convalescent care are not covered.

Home Visits by a Designated Provider

A home visit (house call) by a Designated Provider who provides care to a Participant in the Participant's home or other place of residence.

Home Health Care by Home Health Agency Personnel

The Plan covers visits by home health agency personnel in your home or other place of residence, up to the number of visits listed in the Schedule of Benefits per calendar year to perform medically skilled services. Preauthorization by the Claims Administrator is required.

A Participant must be homebound for medical reasons and physically unable to obtain medical care as an Outpatient. In addition, the Participant must be under the active care of a Designated Provider in order to be eligible for Home Health Services.

Home health care may include the following:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
- Part-time or intermittent home health aide services that consist primarily of caring for the Participant under the supervision of a registered nurse;
• Physical, occupational, or speech therapy, if provided through a home health agency; and
• Skilled treatments performed by licensed or certified home health agency personnel, including the non-prescription medical supplies and drugs (of the type the Participant would have received in the hospital) used or furnished during a visit by home health agency personnel. Non-prescription medical supplies and drugs may include surgical dressings and saline solutions, but do not include some prescription drugs, certain intravenous solutions, and insulin.

NOTE: Homemaker services are not covered.

Each visit by a participant of a home care team is counted as one home care visit. Four hours of home health aide service are counted as one home care visit.

**Covered Hospice Care Expenses**

Covered services include hospice care ordered by a physician during the period when the hospice has admitted a Participant to its program. Covered services include the following services provided by the hospice:

• Inpatient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility, or in a regular hospital bed.

• Home care services provided by the hospice either directly or under arrangements with other licensed providers, including but not limited to:
  – intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
  – physical therapy, speech therapy, occupational therapy, respiratory therapy;
  – social services;
  – nutritional services;
  – laboratory examinations, x-rays, chemotherapy, and radiation therapy when required for control of symptoms;
  – medical supplies;
  – drugs and medications that are prescribed by a physician and included in the U.S. Pharmacopoeia and/or National Formulary (the Plan will not pay for drugs or medications of an experimental or investigative nature);
  – medical care provided by a Participant’s own attending physician or the hospice physician;
  – counseling and bereavement services provided to children, parents, spouses, and siblings;
  – respite care (the intermittent readmission to the non-acute hospice setting to relieve the family of care responsibilities);
  – DME when preauthorized by the Claims Administrator and obtained through an approved provider; and
  – other appropriate services covered when approved by the Claims Administrator’s Medical Review Department.
Other Medical Services

FAST FACTS

- The Plan covers Medically Necessary equipment, appliances and supplies.
- The Plan provides coverage for clinical trials for treatment studies on cancer that meet certain Plan requirements.
- The Plan provides benefits for breast reconstruction in connection with mastectomy, in accordance with the Women’s Health and Cancer Act.

What You Need to Do

- Call the Claims Administrator to ensure that Preauthorization is obtained for the services listed in this section.
- Be aware of Plan exclusions section.

YOUR COVERAGE

The Plan covers the following Medically Necessary supplies and procedures.

DURABLE MEDICAL EQUIPMENT, PROSTHETIC APPLIANCES AND MEDICAL SUPPLIES

The Claims Administrator will pay for durable medical equipment, prosthetic devices, and medical supplies ordered by a physician and provided by a physician, supplier, or pharmacy. Benefit levels are subject to any limitations indicated in the Schedule of Benefits.

Preauthorization by the Claims Administrator is required for all rentals and purchases of durable medical equipment, prosthetic devices, and medical supplies costing over $250. Repair, replacement, and duplication are not covered if due to loss, neglect, abuse of equipment, or for the convenience or personal preference of the Participant.

Durable Medical Equipment (DME) is equipment that is primarily used to serve a medical purpose, is non-disposable and can withstand repeated use. This equipment is appropriate for use in the home and is generally not useful in the absence of the illness or injury. Durable Medical Equipment includes, but is not limited to, the following items: crutches, apnea monitor, oxygen and oxygen equipment, wheelchairs, special hospital type beds or home dialysis equipment. Covered Medical Services also include orthopedic braces with rigid stays that are used to support a weak portion of the body or to restrict movement in a diseased or injured part of the body. The Claims Administrator will determine whether the item should be purchased or rented. At all times, the maximum payment is the purchase price of the equipment. Blood glucose monitors and supplies are covered under the pharmacy benefit.

Non-implanted Prosthetic Devices are appliances that replace all or part of an absent body part, or they replace all or part of the function of a permanently inoperable or malfunctioning body part. Prosthetic devices include but are not limited to the following items: artificial limbs, breast prosthesis, implanted lenses after cataract surgery, and equipment for enteral and parenteral nutrition. Charges for repair, replacement or duplication are not covered if due to loss, neglect, abuse of device, or for the convenience or personal preference of the Participant.
Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of the illness or injury.

Medical supplies include, but are not limited to, the following items:

- Ostomy bags and skin bond for a diagnosis of colostomy; and
- Support stockings for a diagnosis of phlebitis or other circulatory condition.

NOTE: Supplies used for the treatment of insulin dependent diabetes, including but not limited to Chemstrips, needles and lancets are covered under the Prescription Drug benefit.

Other items may be covered with advance written approval by the Medical Director of the Claims Administrator. In general, the Claims Administrator will follow Medicare guidelines when determining the amount and/or duration of coverage for DME and medical supplies.

**COVERAGE FOR CLINICAL TRIALS FOR TREATMENT STUDIES ON CANCER**

The Plan covers Patient Costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials, when preauthorization for clinical trials is obtained from the Claims Administrator. Please refer to the Section titled “Definitions” for the meaning of “Patient Costs.”

Covered clinical trials must be approved by one of the following:

- The National Cancer Institute;
- An NCI cooperative group or center;
- The FDA in the form of an investigational new drug application;
- The Federal Department of Veterans Affairs; or
- An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

Coverage for Patient Costs incurred during clinical trials will be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial and, on a case-by-case basis, in a Phase I clinical trial.

The coverage outlined in this paragraph will apply only if all of the following three conditions are met:

- There is no clearly superior, noninvestigational treatment alternative;
- The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and
- The Participant, provider, and Claims Administrator’s Medical Director conclude that the Participant’s participation in the clinical trial would be appropriate pursuant to procedures established by the Claims Administrator.
Non-health care services that a Participant may receive as a result of this treatment, costs related to managing the research associated with clinical trials, and investigational drugs and devices are not covered.

**Breast Reconstruction in Connection with Mastectomy**

Pursuant to the Women’s Health and Cancer Act of 1998, if you undergo a mastectomy and elect breast reconstruction in connection with the mastectomy, the following services will be covered:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Covered services will be provided in a manner determined in consultation with you and the provider. The above benefits are subject to applicable Copayments, Deductibles, and amounts above Allowable Amounts as described in the Section titled “Schedule of Benefits.”
Mental Health and Substance Abuse Care

FAST FACTS

- The Plan provides coverage for mental health and substance abuse that is determined to be medically or psychologically necessary. Your benefits for treatment of mental health, alcoholism, and drug abuse depend on:
  - whether you receive care as an inpatient or on an outpatient basis; and
  - whether you are enrolled in the Low Premium Program or the High Premium Program
  - and whether or not the provider is an In-Network or Out-of-Network provider.
- Treatment may be provided through psychiatrists, licensed clinical psychologists, licensed professional counselors, licensed clinical nurse specialists, and licensed clinical social workers.
- See Plan exclusions section for mental health services not covered.

What You Need to Do

- Ensure that the Claims Administrator’s Mental Health Line has preauthorized any admission to a hospital, inpatient facility, partial hospitalization program or intensive outpatient program. Failure to contact the Claims Administrator for Preauthorization will result in denial of benefits, as shown in the Schedule of Benefits. No coverage will be available for care received that is not Medically or Psychologically Necessary.
- Refer to the Schedule of Benefits for details on how each Program covers Mental Health and Substance Abuse treatment.
- Be aware of the type/level of care that the facility will provide and be sure it is covered in your plan with Preauthorization. Note that Residential Care is not covered.

LIMITS ON TREATMENT

You may seek approval for up to the maximum number of days shown on the Schedule of Benefits for inpatient care for mental health and/or substance abuse and the maximum number of visits for outpatient care for non-biologically based mental illnesses.

The outpatient Benefit for non-biologically based mental illnesses has an annual outpatient visit limit that is stated in the Schedule of Benefits. Benefit limits for the Programs apply to both In-Network and Out-of-Network services combined. A Participant cannot, for example, obtain 30 inpatient days under In-Network and 30 more under Out-of-Network in the same calendar year for non-biologically based mental illnesses.

Covered Mental Health Services

Covered mental health services are limited to solution-focused and stabilization treatment of psychiatric disorders that affect the ability to function, as demonstrated by behavioral impairment in a Participant’s capacity to function in interpersonal, occupational or educational settings. Please see the Section titled “Exclusions” for a description of services not covered under this Plan.
Medical or Psychological Necessity
The Plan will pay for only those mental health and substance abuse services that are considered Medically or Psychologically Necessary. This means services that:

• Are appropriate and essential for the diagnosis, evaluation and/or treatment of a mental illness or condition other than mental retardation;

• Are in keeping with national standards of mental health professional practice (psychiatry, clinical psychology, clinical social work);

• Are provided at the level of treatment appropriate to the severity of the patient’s illness and capacity to respond to professionally provided treatment;

• Are within the professional competence of the practitioner providing the care; and

• Can be reasonably expected to improve a Participant’s condition or level of functioning, or at least prevent further deterioration.

Determination of Appropriate Levels of Treatment
In determining the appropriate level of treatment, the Claims Administrator considers:

• The intensity and scope of care necessary to meet Medical or Psychological Necessity; and

• The least restrictive environment that will provide adequate care with the least disruption to the Participant, his or her family, work, school, etc., and that offers the maximum reasonable opportunity for independent or community-assisted functioning.

Levels of Treatment Include:

• Inpatient Hospital - Acute Care Programs/Units.

• Partial Hospitalization - Day and Evening Programs.

• Outpatient Care or Intensive Outpatient Programming.

Outpatient visits do not require Preauthorization. All other mental health services do require Preauthorization. This document is sent to the Participant and the provider of mental health or substance abuse services and will state the type of authorization, number of visits and the time specified for the service. If mental health or substance abuse care is discontinued for more than 90 days, the Participant will be required to obtain a new Preauthorization for care from the Claims Administrator’s Mental Health Line.

Annual and Lifetime Benefit Maximums for Non-Biologically Based Mental Health and Substance Abuse Treatment
Benefits for Non-Biologically Based Mental Health may have annual and lifetime maximums, separate from your medical Benefit maximums, as indicated in the Schedule of Benefits.
**Psychological Testing**

Psychological testing is a highly specialized procedure used in a focused manner to assist the provider with diagnosis and/or treatment planning he or she cannot successfully accomplish through other means (e.g., clinical evaluation, review of relevant history, consultations with other treating providers including but not limited to the Participant’s Primary Care Physician, interviews with parents and teachers, review of school records). Preauthorization for psychological testing is required by the Claims Administrator for coverage to be provided under this Plan. Failure to obtain Preauthorization will result in denial of Benefits.

**Emergency Care**

All admissions for emergency care must be reviewed and authorized by the Claims Administrator. In cases where prior notification is not possible, the Participant or a family member must call the number on the UVa Health Plan ID Card for mental health and substance abuse care within 48 hours or the end of the business day following a weekend or legal holiday, or within 48 hours of when the Participant is physically/mentally able to do so after the Emergency admission. The Plan will provide coverage as follows:

- If the admission met the criteria for an emergency admission, and the Participant provided the required telephone notification, then Benefits will be paid as In-Network benefits.
- If the admission did not meet the criteria for an emergency admission but was Medically Necessary, the Participant provided the required telephone notification, and a Network facility was used, then Emergency Room services will not be covered but inpatient benefits will be paid as In-Network.
- If the admission did not meet the criteria for an emergency admission but was Medically Necessary, the Participant provided the required telephone notification, and an Out-of-Network facility was used, then Emergency Room services will not be covered but inpatient benefits will be paid as Out-of-Network.
- If the admission met the criteria for an emergency admission but the Participant failed to provide the required telephone notification, then Benefits will be paid In-Network or Out-of-Network, depending on whether a Network or Out-of-Network Facility was used.
- If the admission did not meet the criteria for an emergency admission, the Participant failed to provide the required telephone notification, but the admission was Medically Necessary, then Emergency Room services will not be covered, but inpatient benefits will be paid based on whether a Network or Out-of-Network Facility was used.
- If the admission neither met the criteria for an emergency nor was Medically or Psychologically Necessary, then the Participant will be required to pay the total cost of the admission.
Prescription Drugs

FAST FACTS

- Benefits are provided for most FDA-approved Prescription Drugs when prescribed by a physician to treat an injury or illness covered by the Plan. Some drugs require preauthorization. Some drugs may have quantity limits.

- “Prescription Drugs” includes any drug required by law to be dispensed only by a prescription, and also includes saline for nebulization, insulin, insulin syringes and auto-injectors, blood glucose monitoring machines, glucose monitoring test strips, lancets, lancet auto-injectors, and hypoglycemia rescue agents for a diagnosis of diabetes.

- Coverage is provided for both prescribed drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives. Birth control items obtained over-the-counter are not covered.

- Specialized prescription drugs and injectables are covered under the Pharmacy benefit. Participants are encouraged to use the Prescription Drug Claims Administrator’s Specialty Pharmacy to order these drugs and have them delivered to the home, physician office, or any other requested location.

What You Need to Do

- The Copayments for covered drugs purchased through participating retail pharmacies and the mail order program are shown in the Schedule of Benefits.

- Be aware of Copayments. The lowest cost is obtained by using generic drugs.

- Check to see if otherwise non-covered prescriptions can be obtained through the discount price benefit.

The Prescription Drug Plan has a discount price benefit for a number of prescription drugs that are not available through the UVA Health Plan. With the discount benefit, when you use your card to purchase these drugs, you will pay the discounted price negotiated by UVA’s Pharmacy Benefit Manager instead of the full retail price. Although you will still pay 100% of the cost rather than copayment, the cost will be less than the retail cost in most cases. These drugs include, but are not limited to, non-sedating antihistamines, vitamins and diet pills, infertility medication, travel-related drugs, and drugs not considered medically necessary. Experimental or investigational drugs and other standard exclusions will not be included in the discount price benefit.

How the Prescription Drug Plan Works

The Plan has three Copayment levels based on the type of drug. The types of drug are listed below, in order of Copayment amount (from lowest to highest). For actual Copayment dollar amounts, refer to the Schedule of Benefits.

- Generic
- Brand formulary
- Brand non-formulary

The formulary is a list of prescription drugs that provide maximum quality and value to you and the Plan. The Claims Administrator for Prescription Drug coverage uses a committee of
doctors and pharmacists to compare each drug’s safety, effectiveness and cost to determine which drugs provide the most value.

The Plan encourages the use of generic drugs. When the government approves a generic form of a drug, the Plan will only pay the cost of the generic drug. If a generic drug is approved and you elect to have the brand name drug instead, or if your physician does not allow substitutions for brand name drugs, the difference between the cost of the brand name drug and the generic will be your responsibility in addition to the appropriate Copayment for the brand medication.

HOW TO FILL YOUR PRESCRIPTION

**Participating Pharmacy**

When you fill a prescription at a pharmacy that participates in the prescription drug network, you just present your ID card when you request your medication. You’ll pay your Copayment and receive your medication. To find out if your pharmacy participates in the network, consult the list of nationally participating pharmacies on the University Human Resources webpage. The list is also available by calling the Pharmacy Benefit Manager’s Customer Service Department.

**Non-Participating Pharmacy**

If you fill your prescription at a Non-Participating Pharmacy or a Participating Pharmacy without presenting your valid ID card, you must pay the full cost of your prescription then file a paper claim with the Pharmacy Benefit Manager for reimbursement up to the Allowable Amount, less the applicable Copayment. You will pay the difference between the Allowable Amount and the billed amount as well as the applicable Copayment.

**Mail Order Program**

You can save money when you purchase “maintenance medications” through the mail order program. A special mail order Copayment applies for up to a 90-day supply of maintenance drugs. Maintenance Medications are drugs you require on an on-going basis. Examples of maintenance medications include those you take for high blood pressure, heart conditions or diabetes. Contact the Prescription Drug Claims Administrator for details on mail order coverage, online at www.pharmcare.com, or call 1-866-UVA-3707.

PREAUTHORIZATION

Some drugs and injectable medications require demonstrated step-therapy (proof that you have unsuccessfully tried other medications first) or Preauthorization by the Pharmacy Benefits Manager. These are listed on the University Human Resources Benefits website.

INJECTABLES AND SPECIALTY MEDICATIONS

Specialized prescription drugs and injectables are covered under the pharmacy benefit and are limited to a 30-day supply. Injectable drugs used at home and in the physician's office, and in outpatient settings must be purchased through this program rather than through the medical plan. Medications can be delivered directly to your home or the physician’s office for administration. Contact Specialty Pharmacy at 1-800-251-9573 to order injectables and specialty medications.
DRUGS THAT ARE NOT COVERED UNDER THE THREE-TIER COPAYMENT BUT MAY BE AVAILABLE UNDER THE DISCOUNT BENEFIT PRICE STRUCTURE

Certain drugs that are excluded under the Plan, may be covered under the Discount Benefit price structure, including but not limited to:

- Drugs or medicines (other than injectable insulin) that can be purchased without a physician's prescription including non-sedating antihistamines;
- Vitamins and diet pills;
- Nutritional Prescription Formulas and supplements;
- Drugs not considered Medically Necessary, including psoralens and tretinoin (Retin-A) for cosmetic use, minoxidil lotion (Rogaine), and nystatin oral powder;
- Infertility medication; and
- Travel-related drugs, medicines, or immunizations.

DRUGS THAT ARE NOT COVERED UNDER THE PLAN

- Experimental or investigational drugs;
- Drugs or medicines prescribed or dispensed by any person in a Participant’s immediate family, defined as including parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews;
- Drugs or medicines prescribed or dispensed by the Participant themselves; and
- Injected drugs administered intrathecally that are customarily administered in an inpatient facility.
Dental Care

FAST FACTS

- Dental Care is provided under the University of Virginia Health Plan as a covered benefit for active Employees and their eligible dependents and COBRA Participants and their eligible dependents. It is an optional coverage for participating retirees and their eligible dependents. In other words, retirees must enroll in dental coverage separately from medical coverage and pay a separate monthly premium for coverage.

- The Dental Claims Administrator provides a Network of dentists from which you may access services. Each time you need dental care, you decide whether or not to use a network dentist.

- When you use network dentists, you will not be subject to “balance billing” (the billing of charges exceeding our Allowable Amount) and will not be required to file claim forms. You may still use non-Network dentists, but you may be subject to balance billing and may have to file your own claims for reimbursement.

What You Need to Do

- Consult the dental provider directory for a listing of network dentists available in your area.

YOUR COVERAGE

The Claims Administrator, on behalf of The University of Virginia, will pay for the dental services described in this Section when they are Medically Necessary, industry standard and performed by a person licensed to practice dentistry. These services are subject to the age or frequency limitations, if applicable, indicated in the Schedule of Dental Benefits. A summary of your dental coverage is shown in the chart below.
SUMMARY OF YOUR DENTAL COVERAGE

| Diagnostic and Preventive Services (Type A) | • Oral examinations;  
• Dental x-rays, except x-rays for orthodontic purposes (cephalometric film);  
• Direct fluoride application to natural teeth (See Schedule of Benefits for age limit);  
• Prophylaxis (includes only cleaning, scaling, and polishing);  
• Palliative emergency treatment;  
• Space maintainers (not made of precious metals);  
• Biopsies of oral tissue;  
• Pulp vitality tests; and  
• Gingival curettage (with limit of 2 cleanings/year covered total, including general prophylaxis). |
|--------------------------------------------|

| Primary Services and Maintenance Services (Type B) | • Fillings made of amalgam or tooth color synthetics;  
• Endodontics;  
• Periodontic Services which consist of:  
  • Gingivectomy and gingivoplasty;  
  • Osseous surgery, including flap entry and closure;  
  • Mucogingivoplasty surgery; and  
  • Management of acute periodontal infection and oral lesions.  
• Oral Surgical Services, including Dental Services for oral surgery procedures listed in the most recent edition of the “Code of Dental Procedures and Nomenclature of the American Dental Association” are covered. Type A procedures listed above or performed for orthodontic purposes will not be covered under this paragraph. Covered oral surgery procedures include, but are not limited to:  
  • Simple extractions;  
  • Surgical removal of teeth;  
  • Excision, drainage, or removal of cysts, tumors, and abscesses in the mouth;  
  • Apicectomies;  
  • Hemisections;  
  • Treatment of fractures of the jaw; and  
  • Alveoplasties to prepare the gum ridge for dentures. |
|--------------------------------------------|

| Major Restorative Services (Type C) | • Crowns, inlays and onlays;  
• Bridges; and  
• Dentures |
|----------------------------------|

| Orthodontia Care (Type D) | • Braces; and  
• Retainers. |
|--------------------------|

NOTE: If any of the procedures listed above are payable under the medical portion of this Plan, no coverage will be available under Dental Care.

General Anesthesia Services are covered under the Dental Plan only when performed in the dentist's office and when rendered in connection with the dental services outlined in the chart above, by a person licensed to do so. Hospital services and general anesthesia for dental
procedures when determined to be Medically Necessary for a Member who is severely disabled or has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment may be covered under the Medical Plan. Preauthorization is required. Preauthorization of hospitalization and anesthesia should not be construed as preauthorization of payment of dental care incidental to the hospitalization and anesthesia benefit.

LIMITATIONS

If you transfer from the care of one dentist to another during a course of treatment, the Plan will only pay the amount it would pay to one dentist for the same treatment.

If more than one dentist renders services for one procedure, the Plan will only pay the amount it would pay to one Dentist for the same treatment.

DENTAL SERVICES THAT ARE NOT COVERED

The exclusions that apply to medical and hospital services under this Plan apply to this Section when not inconsistent with the terms of this Section. In addition, the following Special Exclusions apply to dental services. Payment will not be made for the following Dental Services:

- Those free or reduced charge services rendered by a dental or medical clinic maintained by the Participant’s employer, a mutual Benefit association, labor union, trustee, or like person or group.
- Those related to genetic malformation.
- Those rendered to an inpatient in a facility by a Dentist paid by that facility to perform such services.
- Gold foil restorations.
- Those not listed in section titled “Summary of Your Dental Coverage” on page 67.
- Instruction in personal dental hygiene and care. This includes plaque control.
- Those rendered as part of optional plans of treatment, personalized restorations, or special techniques, unless approved by the Claims Administrator in advance. If these procedures are not approved, the Claims Administrator will pay only the Allowable Amount for the standard, less expensive procedures.
- Dental implants.
What The Plan Does Not Cover

The following are not covered under this Plan:

**Acupuncture, Acupressure, or Hypno-Therapy**

**Admission to a Hospital before becoming Covered under this Plan:** If a Participant is admitted to a hospital or skilled nursing facility as a registered inpatient before the date he becomes covered under this Plan, the Plan will cover the part of the stay in that hospital or skilled nursing facility, or medical services related to that stay that occurred after the Participant became covered under this Plan. All Preauthorizations must be in place in order to receive reimbursement.

**Biofeedback Services**

**Blood, Blood plasma or derivatives: If a refund or credit is given.**

**Blood Donation:** When a Participant chooses to designate either himself or another person to be a blood donor so that he may receive the designated blood at a future time, the Plan will not cover charges for procurement, storage, or administration of such donated blood or any extra charges associated with designated blood donation, except for autologous blood donation for scheduled surgery. The Plan covers the costs associated with drawing, preparation, and storage of the Participant’s blood donations for use by the Participant, including blood and processing fees.

**Care Provided by a Family Member:** Care (to include the prescribing of prescription drugs) provided by an individual who normally resides in a Participant’s household or is a member of his immediate family, defined to include parents, siblings, spouses, children, grandparents, aunts, uncles, nieces, and nephews.

**Care Received after Termination from this Plan:** If a Participant is in a hospital or skilled nursing facility as a registered inpatient at the time his coverage under this Plan is terminated, the Plan will cover the part of the stay in that hospital or skilled nursing facility, or medical services related to that stay that occurred while the Participant was covered under this Plan. Care received following the effective date of the termination of the Participant’s coverage under this Plan will not be covered.

**Care Rendered in Certain Non-Hospital Institutions:** Care or supplies in convalescent homes or similar institutions, facilities providing primarily custodial or rest care or domiciles; care or supplies in health resorts, spas, sanitariums, or tuberculosis hospitals.

**Charges in Excess of Annual or Lifetime Maximums:** Any service, supply, or treatment in excess of the annual or lifetime maximums shown in the Schedule of Benefits.

**Charges for Missed/Canceled Appointments**

**Chelating Agents:** Any service, supply, or treatment for which a chelating agent is used, except to provide treatment for heavy metal poisoning.
**Chiropractic Services: Correction of Structural Imbalance, Distortion or Subluxation:** Any services or supplies rendered in connection with the diagnosis, detection, and correction (by manual or mechanical means) of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. See Schedule of Benefits for any exceptions to this exclusion.

**Convenience Items:** Items that are primarily for convenience. These are items that are not directly related to the provision of Covered Medical Services. Such items include, but are not limited to, telephone and television rental charges, and equipment primarily for the convenience of the caregiver.

**Cosmetic Surgery:** Any procedures, services, equipment, or supplies provided in connection with elective cosmetic surgery that is intended primarily to improve appearance or for your psychological Benefit. The Plan will, however, cover services (other than Dental Care services) to correct significant functional defects or functional impairments that result from an acquired and/or congenital disease or injury that occurs while a Participant is covered under the Plan. The Plan will also cover reconstructive surgery to correct significant congenital malformations or anomalies (other than dental malformations or anomalies) resulting in a functional defect or impairment of a covered child.

**Criminal Acts:** Charges incurred as the result of injuries sustained during the commission of a felony.

**Custodial Care:** Hospital care, nursing home or skilled nursing facility care, home care or any other service that is custodial in nature. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating, and taking medicine.

**Dental Care:** Dental Care is covered under the Dental Care Plan. See the Section titled “Dental Care” and the Section titled “Schedule of Dental Benefits” for covered Dental Services. The following dental services are excluded from the Hospital and Medical Benefits Coverage: Treatment of cavities and extractions; care of the gums or bones supporting the teeth; treatment of periodontal abscess; treatment of dentigerous cysts; orthodontia (including braces); false teeth; soft tissue impactions, orthognathic surgery (unless treatment is sought from a PCP for medical symptoms and the medical treatment is approved in advance by the Claims Administrator); anesthesia/facility charges incurred in association with dental treatment whose need is based solely on behavioral or psychological issues, except when the participant is a child under age 5 when such services are required to effectively and safely provide dental care; or any other dental services; appliances or devices even if ordered for medical reasons; or any other dental services. The Plan will, however, cover any services or supplies in connection with a documented accidental injury to sound natural teeth for expenses incurred within six (6) months from the date of the accident. See the Section titled “Dental Care” and the Section titled “Schedule of Dental Benefits” for any exceptions to this exclusion.
**Equipment**: Air conditioners, humidifiers, air purifiers, exercise equipment, arch supports, orthotics, or any other type of personal convenience item.

**Experimental/Investigative Procedures and Related Equipment and Supplies**: Procedures or services, including some transplants, which are experimental or investigative in nature; nor will the Plan pay for equipment or supplies related to experimental procedures.

**Eye Surgery**: Eye surgery to correct myopia, including, without limitation, radial keratotomy, and laser procedures.

**First Aid Supplies and Over-The-Counter Equipment**: Common first aid supplies, elastic braces or supports, corrective shoes, canes, traction apparatus, cervical collars, and corsets, among others.

**Foot Care**: Services or supplies for weak, strained, flat, unstable, or unbalanced foot or for a metatarsalgia or bunion. This does not apply to an open cutting operation. Routine or cosmetic foot care including trimming of hyperkeratotic lesions, calluses and nails, except for foot care for diabetics. Foot orthotics, arch supports, corrective shoes, shoe inserts, heel elevations and fittings for such devices.

**Free Care**: The Plan will not cover any care if the care is furnished without charge or would normally be furnished without charge. This exclusion also applies if the care would have been furnished without charge if the Participant were not covered under this Plan or under any other health Benefit plan or other insurance.

**Genetic Testing**: Genetic coverage that is excluded from UVa Health Plan coverage includes pre-implantation testing, parent prenatal testing and genetic testing for polymorphisms to predict drug response.

**Government Programs**: Where permitted by law, Covered Medical Services to the extent that Benefits for such services are payable under Medicare or any other federal, state or local government program, except that the Plan will pay even though a Participant is eligible for Medicaid. The Plan will not cover treatment of disabilities from diseases contracted or injuries sustained as a result of military service.

**Imaging**: Diagnostic x-rays in connection with research, study, or for fluoroscopy without film.

**Infertility Services**: Infertility services such as artificial insemination, in vitro fertilization, or other infertility procedures or treatment to promote conception, including drug therapy. Some diagnostic services to identify the causes of infertility are covered with pre-authorization by the Claims Administrator.

**Instructional Programs**: Charges for instructional or educational programs and support groups such as, but not limited to, childbirth classes, vocational training/testing, smoking cessation classes, nutritional training, and those dealing with lifestyle changes unless otherwise specified in the Description of Benefits as a covered service or except as part of the Claims Administrator’s organized Health and Disease Management Programs.
**Insulin:** Insulin injections or other insulin therapy except to the extent covered under the Section titled “Prescription Drugs.”

**Interruption of Pregnancy:** Due to elective surgical or pharmaceutical abortion, except to the extent detailed as follows (if not otherwise contrary to law): a.) when Medically Necessary to save the life of the mother; b.) when the pregnancy occurs as a result of rape or incest and has been reported to a law-enforcement or public health agency; or c.) when a fetus is believed to have an incapacitating physical deformity or incapacitating mental deficiency and this is certified by a physician.

**Laboratory:** Services Related to non covered services, such as infertility, certain genetic tests and non covered services.

**Mammoplasty:** Performed for reasons of augmentation, asymmetry, or removal of silicone implants, except as covered under the Women’s Health and Cancer Act.

**Mandated or Court Ordered Care:** Any medical, psychological, or psychiatric care that is the result of a court order or otherwise mandated by a third party (such as an employer or licensing board), unless such care is determined to be Medically or Psychologically Necessary.

**Medical Reports:** Special medical reports not directly related to treatment; appearances at hearings and court proceedings.

**Medical Services or Supplies for Control of Obesity or Morbid Obesity:** Any medical services or supplies intended for control of either obesity or morbid obesity, such as dietary control, counseling, or weight maintenance programs, even if the obesity or morbid obesity aggravates another condition or illness. Medically Necessary surgical treatment for morbid obesity through gastric bypass surgery or other such methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity will be covered if preauthorized. If surgical treatment is preauthorized and performed, cosmetic surgery such as abdominoplasties or panniculectomies requested as a result of rapid weight loss related to a gastric bypass procedure will not be covered.

**Mental Health and Substance Abuse Services:** Covered Medical Services do not include the following conditions and treatments for mental health and substance abuse services:

- Psychological assessment for the primary purpose of academic or intellectual assessment; educational placement; diagnosis of learning disabilities; or determination of eligibility for special education, vocational, or rehabilitation services.

- Services that are extended beyond the period necessary for the evaluation and diagnosis for mental retardation.

- Sexual therapy and/or sexual therapy programs.

- Residential Treatment.

- Treatment for smoking or nicotine cessation.

- Marital counseling.

- Long term mental health and substance abuse services including treatment for mental retardation, educational services for learning and behavioral disabilities, and behavior training.
• Psychotherapy in which the primary focus is characterologic or personality change, or in which the primary goal is the enhancement of personal growth, in the absence of significant and observable functional impairment.

• Mental health and substance abuse research, study, or experimental treatments or programs.

**Non-covered Services:** Laboratory tests, office visits, hospital stays, and other services related to, or arising from, a noncovered service even if the service is otherwise Medically Necessary.

**Nutritional Counseling:** Dietary control counseling or weight maintenance programs, even when the diagnosis is obesity or morbid obesity or eating disorder. Nutritional counseling as part as a part of diabetes education may be available with Preauthorization by the Claims Administrator.

**Nutritional Supplements**

**Organ Donation Services:** Organ transplant services related to donation of an organ by a Participant; artificial organs and services related to the implantation, and other related services, except as specified in the Section titled “Transplant Benefits.”

**Physical Therapy and Occupational Therapy:** Services for members diagnosed as having special learning needs or developmental delay disorders.

**Premarital Laboratory Work:** Premarital laboratory work required by any state or local law.

**Prescription and Non-prescription Drugs:** See the Sections titled “Prescription Drugs” and “Schedule of Benefits” for a list of exclusions to Prescription Drug Benefits. All non-prescription drugs are excluded.

**Private Duty Nurses:** Refer to the Home Health Benefit for coverage limitations.

**Private Room:** If a Participant occupies a private room, he will have to pay the difference between the hospital’s charges for a private room and the hospital’s most common charge for semi-private accommodations, unless it is Medically Necessary for the Participant to have a private room.

**Required Examinations:** Examinations specifically for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses, or examinations before engaging in athletic or recreational activities or attending a school, camp, or other program, unless obtained in the context of the periodic examination described in the Section titled “Medical Services.”

**Reversal of Sterilization**

**Sclerotherapy:** Injection of sclerosing solutions for the treatment of varicose veins.

**Second Surgical Opinion and Consultation with Specialist:** The Plan does not cover both a second surgical opinion and a consultation with a specialist with respect to the same surgical procedure.

**Services Normally Considered Non-Covered:** Services and supplies that are normally not covered under this Benefit Plan. This includes services for which the Plan is secondary under Coordination of Benefits.
Services not Specified as Covered: Any services not specifically described in this Plan.

Sex-Change Treatment: Surgical procedures or related care, including drug therapy, to alter a Participant’s sex from male to female or female to male.

Sexual Dysfunction, Sexual Aids, or Sex Transformation: Treatment for sexual dysfunction, sexual aids, or sex transformation or the reversal thereof are not covered. This includes medical and mental health services.

Speech Therapy: Speech therapy treatment of children diagnosed as having special learning disabilities or developmental delay disorders.

TENS Unit: Rental or purchase of TENS Unit.

Transplant Services: Transportation and/or lodging costs of the transplant recipient or individuals traveling with him or her unless the Plan requires the Participant to obtain services from a designated network transplant facility outside the Service Area; nor will the Plan pay for transplants using artificial parts or non-human donors.

Travel and Transportation Expenses: The Plan will not cover travel and transportation expenses, even though prescribed by a physician, except for ambulance service or transfer authorized in advance, for limited non-emergency ambulance service. Medical evacuation and repatriation are not covered.

Travel Related Immunizations: Immunizations for the purpose of fulfilling requirements for international travel and oral medications taken in preparation for or during international travel.

Vision and Hearing Care: Under this Plan, routine hearing examinations (except that the Plan will cover a well baby pediatric examination), eyeglasses, contact lenses, hearing aids, and other vision care and hearing care services and supplies. However, Covered Medical Services required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears, are covered. (Such as diabetes)

Work-Related Injuries: Any services for injuries or illnesses arising from any employment or occupation when:

- A Participant receives payment from his employer due to the illness or injury;
- A Participant’s employer is required by federal, state, or local laws or regulations to provide Benefits to the Participant; or
- The Participant could have received Benefits for the injury or illness if he had complied with the laws or regulations.

* Note: Services that may have been related to employment or occupation will be covered only upon denial of coverage by the Participant’s employer (or employer’s insurance company) for Workers’ Compensation coverage. This work-related injury exclusion applies whether or not the Participant has waived his rights to payments for services available. It also applies if the Participant’s employer (or employer’s insurance company) reaches any settlement with the Participant for an injury or illness related to the Participant’s employment.
Coordination of Benefits (COB)

FAST FACTS

• Members of a family are often covered under more than one group health plan, possibly resulting in duplication of health coverage. To avoid this, the health care benefits provided by this Plan are coordinated with similar benefits payable under other plans.

• Under the Coordination of Benefits (COB) provision, if you are insured under any other group health plan, the total payment you receive from all plans may not be more than 100% of the “Allowable Amounts.” Allowable Amounts are the necessary, usual and customary expenses for medical services, treatment or supplies covered under this Plan.

• When a Health Care Benefits Plan provides Benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be an Allowable Amount and a Benefit paid.

What You Need to Do

You must report other group health insurance coverage that you or your covered dependents have when you submit a claim form for benefits.

METHODS OF COORDINATION

If you have duplicate health coverage, your benefits are coordinated by looking at the “primary plan” first. If any charges still need to be paid, they will be applied to the “secondary plan.” The following rules determine whether a plan is “primary” or “secondary”:

• If one plan does not have a Coordination of Benefits provision, it will be the primary plan.

• If the patient is covered as an Employee under one plan and as a dependent under the other, then the plan under which the person is covered as an Employee will be the primary plan.

• If one health plan covers the person because the person or his or her spouse, parent or other dependent is a retiree or former Employee of the plan sponsor (the “Retirement Plan”) and the other plan covers the person because the person or his or her spouse, parent or other dependent is an active Employee (the “Active Plan”), then the Active Plan is the primary plan and the Retirement Plan is the secondary plan.

• To the extent permitted by applicable law, when any Benefits are available as primary Benefits to a Participant or his or her covered spouse or covered dependents under Medicare or any workers’ compensation laws, occupational disease laws and other employer liability laws, those Benefits will be primary.

• If the patient is a dependent child covered under both parents’ plans, the plan of the parent whose birthday falls earlier in the year will be the primary plan. If both parents have the same birthday (only the month and day are considered), the plan that covered the parent longer will be the primary plan. However, if one plan does not have this rule, but instead has a rule based on the gender of the parent and, as a result, the plans do not agree on which is primary, then the father’s plan will be the primary plan.

• If none of the rules for determination of order of payment apply, then the plan under which the Participant has been enrolled the longest will be the primary plan.
**Child Custody in Divorce**

If the parents are divorced or legally separated, the following guidelines apply:

- When a court decree has established which parent has financial responsibility for the child’s health care expenses, then that parent’s plan will be the primary plan;
- When financial responsibility has not been established, then the plan which covers the child of a parent with legal custody will be the primary plan; or
- When financial responsibility has not been established and the parent with legal custody remarries and the stepparent’s plan also covers the child as a dependent, the order of primacy is as follows:
  - the plan of the parent with legal custody;
  - the plan of the stepparent; or
  - the plan of the parent without legal custody.

**Other Health Care Benefit Plans That This Plan Coordinates With**

For purposes of this Section only, “Health Care Benefits Plan” means any of the following (including this Plan) which provide Benefits or services for, or by reason of, medical care or treatment:

- Coverage under government programs, including Medicare and Medicaid, required or provided by any statute in accordance with the limitations of law.

- Any group or individual health insurance policy, contract or other arrangement, including automobile insurance coverage, where a health Benefit is to be provided, arranged, or paid for, on an insured or uninsured basis; and any coverage for students that is sponsored by, or provided through a school or other educational institution above the high school level. The term “Health Care Benefits Plan” will be interpreted separately with respect to that part of any such policy, contract, or other arrangement that has the right to take the Benefits of the other Health Care Benefits Plan into consideration in determining its Benefits and that part that does not take such Benefits into consideration.

**Right to Coordinate Benefits**

The Claims Administrator has the right to coordinate Benefits between this Plan and any other Health Care Benefits Plan covering a Participant. If this happens, reimbursement under the two or more plans will not exceed 100% of the actual Allowable Amount incurred by the Participant.

One plan (the primary plan) will pay its full Benefits. The other plan (the secondary plan) may pay any Allowable Expenses in excess of the primary plan Benefits, up to the maximum amount that it would pay if the Coordination of Benefits provision were not in force.

When this Plan is the primary plan, full Benefits covered under this Plan will be provided.

When this Plan is the secondary plan, the Claims Administrator will provide Benefits coordinated with the primary plan so that the two plans will pay up to the Allowable Expenses incurred by the patient. The Claims Administrator will never pay more than it would have paid if this Plan were the primary plan.
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Under the Plan, the Claims Administrator has the right to release or obtain information that it believes necessary to process a claim for Benefits and to otherwise carry out the purpose of this Section. The Participant agrees to furnish to the Claims Administrator any information that the Claims Administrator reasonably requests in order to process a Participant. If a Participant does not furnish the information, the Claims Administrator may deny claim payments.

PAYMENTS TO OTHER HEALTH BENEFITS PROGRAMS

On UVa’s behalf, the Claims Administrator may repay to any other Health Care Benefits Plan the amount that the other plan paid for Covered Medical Services and that the Claims Administrator determines this Plan should have paid. These payments are the same as Benefits paid and satisfy any obligation to a Participant under this Plan.

COORDINATION OF BENEFITS IN TRANSPLANT CASES

Coverage of organ and human tissue procurement Benefits (tissue typing, surgical procedure, storage expense, and transportation costs) directly related to the donation of an organ or human tissue by another person to the Participant (Donation Benefits) will be as follows:

- If the donor is covered under another Health Care Benefits Plan that includes coverage for donations used in the covered transplant procedure, then the donor’s plan will be primary and this Plan will be secondary.
- If the donor is not covered by any Health Care Benefits Plan or is covered under a Health Care Benefit Plan that excludes donation Benefit from coverage, then this Plan will be primary.

COORDINATION OF BENEFITS FOR ACTIVE EMPLOYEES WITH MEDICARE

An active Employee or his or her covered dependent may have coverage under the Plan and under Medicare because of age or disability. Medicare means the Benefits offered under Title XVII of the Social Security Act, and includes all of the Benefits provided by Medicare Part A (hospital insurance) and Medicare Part B (supplementary medical insurance).

When a Participant has coverage under both the Plan and Medicare, the Plan will pay primary Benefits for:

- An active Employee who is age 65 and over;
- An active Employee’s spouse age 65 and over;
- An active Employee under age 65 entitled to Medicare because of disability;
- An active Employee’s spouse under age 65 entitled to Medicare because of a disability; or
- The first 30 months of treatment for End Stage Renal disease received by any Participant.

If a Participant does not fall into one or more of the categories above, the Plan will pay Benefits secondary to Medicare. When the Plan is secondary, the Participant must first submit the claim to Medicare. After Medicare makes payment, the Participant may submit the claim to the Plan for payment. If a participant does not elect Part B coverage, the payment to be made by the Plan will be made as if the participant had elected Part B.
These rules are based on regulations issued by the Health Care Financing Administration (HCFA), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer Rules. If the Plan in any way conflicts with regulations issued by HCFA, the Plan will pay Benefits in accordance with HCFA regulations.

A Participant who is covered under Medicare and the Plan, and who falls into the categories above, may elect to waive coverage under the Plan. If coverage is waived under the Plan, the Plan will no longer provide coverage for that person. If a Participant waives coverage under the Plan, the Participant may later reapply for coverage under the Plan as a Late Enrollee. The rules governing Late Enrollees will apply. If a Participant elects Medicare as the primary coverage, the Participant will have no further coverage under this Plan.

**Coordination of Benefits For COBRA Enrollees with Medicare**
A COBRA enrollee or his covered dependent may have coverage under the plan and under Medicare because of age or disability only if the Medicare coverage began prior to the start of the COBRA coverage. When a participant has coverage under both the Plan and Medicare, Medicare will pay primary benefits.

**When Retirees Become Medicare Eligible**
Once a retiree becomes eligible for Medicare, coverage under the Plan will end.

The Commonwealth of Virginia provides a health insurance group plan for retirees who receive VRS, FRP, or MCRP retirement income. The University Human Resources Benefits Division will assist you with the health insurance application if you elect coverage for yourself and dependents at the time you retire. Your spouse will be able to continue coverage for the rest of his or her life in the event of your death if both of you elect coverage when you retire. If you are ineligible for Medicare when you retire, your will be covered by the UVa Health Plan.

If you are a retiree eligible for Medicare, the state insurance program is available to you as secondary coverage after Medicare.
## General Plan Information

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>The University of Virginia Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Sponsor</td>
<td>The Plan Sponsor is the employer, The University of Virginia (UVa). The address and telephone number of the Plan Sponsor is: 914 Emmet Street P.O. Box 400127 Charlottesville, Virginia 22904-4127 434-924-4392</td>
</tr>
<tr>
<td>Hospital and Medical Claims Administrator</td>
<td>The University of Virginia Health Plan is supervised and administered by: Southern Health Services, Inc. Town Center One 1000 Research Park Boulevard Charlottesville, Virginia 22911 1-888-975-9557 <a href="http://www.southernhealth.com">www.southernhealth.com</a> Southern Health Services, Inc., a fully owned subsidiary of Coventry Health Care, Inc., is licensed in the Commonwealth of Virginia as a Health Maintenance Organization (HMO) and acts as a Third Party Administrator. The Third Party Administrator may elect to subcontract certain services.</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Claims Administrator</td>
<td>The University of Virginia Health Plan is supervised and administered by: United Behavioral Health P.O. Box 411517 Saint Louis, Missouri 63141-3517 1-800-975-8919</td>
</tr>
<tr>
<td>Prescription Drug Claims Administrator</td>
<td>The University of Virginia Health Plan is supervised and administered by: CVS Caremark 620 Epsilon Drive Pittsburgh, PA 15238 1-866-UVA-3707</td>
</tr>
<tr>
<td>Dental Claims Administrator</td>
<td>The University of Virginia Health Plan is supervised and administered by: United Concordia Insurance Company 4401 Deer Path Road Harrisburg, PA 17110 1-866-215-2354 <a href="http://www.ucci.com">www.ucci.com</a> United Concordia operates in the Commonwealth of Virginia as a Third Party Dental Claims Administrator. The Third Party Administrator may elect to subcontract certain services.</td>
</tr>
<tr>
<td>Plan Year</td>
<td>The Plan Year runs from January 1st to December 31st of each calendar year.</td>
</tr>
<tr>
<td>Plan Identification Number</td>
<td>The Plan is required to have a Federal Tax Identification Number for government reporting purposes. This number is 54-6001796. This Plan also has a separate filing number for making annual reports to government agencies. This number is 501.</td>
</tr>
<tr>
<td>Type of Administration</td>
<td>Contract Administration.</td>
</tr>
<tr>
<td>Plan Funding Arrangement</td>
<td>The Plan is financed by the University of Virginia and by contributions made by covered Employees, COBRA enrollees, and Retirees. Benefit payments and administrative expenses are provided from the general assets of UVa and from the Employee contributions that have been deducted from Employee salaries for Plan coverage and from retiree and COBRA premiums.</td>
</tr>
</tbody>
</table>
Filing Complaints and Appeals

UVa recognizes the need to respond in a timely and effective manner to your questions, concerns and complaints. As a result, UVa has contracted with the Claims Administrators of the Plan to administer complaint procedures on its behalf as described in this Section.

<table>
<thead>
<tr>
<th>For complaints or appeals regarding:</th>
<th>Contact the Claims Administrator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your medical and hospital benefits</td>
<td>Southern Health Services, Inc.</td>
</tr>
<tr>
<td></td>
<td>Attention: Appeal Coordinator</td>
</tr>
<tr>
<td></td>
<td>9881 Mayland Drive</td>
</tr>
<tr>
<td></td>
<td>Richmond, VA 23233</td>
</tr>
<tr>
<td></td>
<td>800-627-4872</td>
</tr>
<tr>
<td></td>
<td>Fax Number: 804-747-8836</td>
</tr>
<tr>
<td>Your mental health and substance</td>
<td>United Behavioral Health</td>
</tr>
<tr>
<td>abuse benefits</td>
<td>Attn: Appeals/Complaints</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 411517</td>
</tr>
<tr>
<td></td>
<td>Saint Louis, Missouri 63141-3517</td>
</tr>
<tr>
<td></td>
<td>Telephone: 1-800-975-8919</td>
</tr>
<tr>
<td></td>
<td>Facsimile: 1-866-209-9317</td>
</tr>
<tr>
<td>Your prescription drug benefits</td>
<td>CVS Caremark</td>
</tr>
<tr>
<td></td>
<td>Clinical Department</td>
</tr>
<tr>
<td></td>
<td>620 Epsilon Drive</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15238-2845</td>
</tr>
<tr>
<td>Your dental benefits</td>
<td>United Concordia</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 69420</td>
</tr>
<tr>
<td></td>
<td>Harrisburg, PA 17110</td>
</tr>
</tbody>
</table>

You are entitled to coverage if you are eligible for Benefits according to the provisions of this Plan. A person has no rights under this Plan if he is not entitled to coverage. No clerical error will invalidate a Participant’s coverage if it would otherwise be validly in force.

No legal action may be taken against the Plan until all Complaint Procedures and Appeal rights, as described in this Plan, have been exhausted. In the event that legal papers need to be served regarding this Plan, service may be made on the Plan Sponsor.

UVa Health Plan Ombudsman
You may contact the UVa Health Plan Ombudsman with questions regarding the Complaints and Appeals Procedures outlined in this section at:

UVa Health Plan Ombudsman
University Human Resources Benefits Division
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127.

Phone: 434-924-4392
Email: healthplanombuds@virginia.edu
FILING COMPLAINTS AND APPEALS FOR MEDICAL AND HOSPITAL CARE

The complaint procedures give you the opportunity to ask the Claims Administrator to review any matter related to:

- The quality of health care service received;
- General inquiries about Covered Services; or
- Your rights.

The appeals procedures give you the opportunity to ask the Claims Administrator to review any matter related to:

- Issues about the scope of coverage for health care services;
- Medical Necessity of services requested;
- Denial of care/services/claim; or
- Other Adverse Benefit Determinations, as defined below.

A complaint or appeal that involves a physician or other contracted provider will require information from that provider in the resolution of the complaint/appeal. Complaints/appeals involving an institutional or ancillary provider will be forwarded to the provider for review through the provider's internal appeal process. The Claims Administrator will monitor the provider's resolution process and will require the provider to keep the Claims Administrator abreast of its decision.

Providers may also file complaints and appeals on their own behalf. They have a separate appeals process, which is outlined in their Provider Contract.

Definitions for Complaint and Appeal Procedures for Medical and Hospital Care

The following definitions apply to the Medical and Hospital Care Complaint and Appeal Procedures.

**Adverse Administrative Decision:** An Adverse Benefit Determination that is not an Adverse Decision.

**Adverse Benefit Determination:** A denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit. An Adverse Benefit Determination based in whole or in part on a medical judgment, including the failure to cover services because they are determined to be Experimental/Investigational or not Medically Necessary, is also considered a final Adverse Decision.

**Adverse Decision:** An Adverse Decision is a utilization review determination by the Claims Administrator that the health care service rendered or proposed to be rendered was or is not Medically Necessary, when such determination may result in noncoverage of the health care service. A final Adverse Decision is a type of Adverse Benefit Determination that may result in an Independent External Review.
**Authorized Representative:** An Authorized Representative is an individual authorized by the Member or state law to act on the Member’s behalf in obtaining claim payment or during the appeal process. A provider may act on the Member’s behalf with the Member’s express written consent for all appeals except Expedited Appeals when the provider does not need the Member’s express consent to act as Authorized Representative.

**Complaint:** A Complaint is an inquiry to the Claims Administrator about Covered Services, Member rights or other issues or the communication of dissatisfaction about the quality of service or benefit or other issue which is not an Adverse Benefit Determination. Complaints do not involve utilization review decisions.

**Expedited (Urgent Care) Appeal:** An Expedited Appeal is an appeal that must be reviewed under an expedited process because the application of non-expedited appeal time frames could seriously jeopardize a Member’s life or health or the Member’s ability to regain maximum function. In determining whether an appeal involves urgent care, the Claims Administrator must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving (a) care that the treating physician deems urgent in nature; (b) the treating physician determines that a delay in the care would subject the Member to severe pain that could not adequately be managed without the care or treatment that is being requested; or (c) the Member is a cancer patient and the delay would subject the Member to pain. Such appeal may be made by telephone, facsimile or other available similarly expeditious method.

**Independent External Review:** If the Member receives a final Adverse Decision of an appeal, the Member or the Member’s Authorized Representative which may include the treating provider may appeal the Adverse Decision by filing a request for an Independent External Review. The Independent External Review process is explained below.

**Physician Advisor:** A Physician Advisor is a physician licensed to practice medicine in Virginia or under a comparable licensing law of a state of the United States and who provides advice regarding the medical necessity of a service to the Claims Administrator as part of its utilization review activities.

**Post-service Appeal:** A Post-service Appeal is an appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

**Pre-service Appeal:** A Pre-service Appeal is an appeal for which a requested service requires Prior Authorization, an Adverse Benefit Determination has been rendered, and the service has not been provided.

**Reconsideration:** A review of an Adverse Decision by either the Claim Administrator’s Medical Director, a Physician Advisor, a peer of the treating provider who is licensed in the provider’s same or similar specialty, or a panel of other appropriate health care providers with at least one Physician Advisor or peer of the treating health care provider on the panel. The provider on behalf of the Member shall request a Reconsideration of an Adverse Decision.
<table>
<thead>
<tr>
<th>To initiate a complaint</th>
<th>Call the Claims Administrator (Southern Health Services) or write to them within 90 days – i.e., within 90 days of receiving notice of a denial of benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of time the Claims Administrator has to respond to your complaint</td>
<td>30 days</td>
</tr>
<tr>
<td>To initiate a Level I Appeal</td>
<td>Write to the Claims Administrator within 180 days of the date you received written notification of the denial of your complaint/claim or the incident that gave rise to the appeal</td>
</tr>
</tbody>
</table>
| Amount of time the Claims Administrator has to respond to your Level I Appeal | You will receive a letter notifying of receipt of your appeal within 5 days  
- You will receive a letter outlining the determination of your appeal within:  
  - 15 days for a service you have not yet received; or  
  - 30 days if the appeal is for a service that you have already received  
  Note: If you requested an expedited appeal for a decision involving urgent care, you will receive notice of the decision with 72 hours of your expedited appeal. |
| To initiate a Level II Appeal | Write to the Claims Administrator within 31 days of the date you received notice of the Level I Appeal decision. |
| Amount of time the Claims Administrator has to respond to your Level II Appeal | You will receive a letter outlining the determination of your appeal within:  
- 15 days for a service you have not yet received; or  
- 30 days if the appeal is for a service that you have already received  
In no case will the decision letter be sent later than five days after the decision was made. |
| To requests a Reconsideration of a Medical Necessity Determination | Write to the Claims Administrator within 90 days of the date you received written notification of the denial or of the incident that gave rise to the initial Adverse Decision. |
| Amount of time the Claims Administrator has to respond to your request | 10 working days following the Claims Administrator’s receipt of the request. |
| To appeal an adverse decision | Write to the Claims Administrator within 180 days of the date you received the notice of the adverse decision |
| Amount of time the Claims Administrator has to respond to your adverse decision appeal | 30 days for a service you have not yet had  
60 days for a service that you have already received |
| To request external review of your appeal by the University Ombudsman | Write to the University Ombudsman within 30 days after you receive written notice of denial. |
| Amount of time the University Ombudsman has to respond to your request | 30 days from the date of receipt of your request for external review. |
If You Have a Complaint
You or your authorized representative can initiate the complaint process verbally, by calling
Southern Health Services, or in writing to:

Southern Health Services, Inc.
Attention: Customer Service Department
P.O. Box 7704
London, Kentucky 40742

Complaints must be received within 90 days of the date you or your authorized
representative received written notification of the issue that is the basis of the complaint or of
the incident that gave rise to the complaint. All complaints will be initially addressed at the
staff level.

Communication and Resolution
General complaints about providers (i.e. matters involving interactions with office staff or
Referral matters) are forwarded to Provider Relations. Quality of care, treatment, or provider
access complaints are forwarded to Quality Improvement. Complaints related to administrative
issues or coverage decisions where Medical Necessity is not an issue are handled by Customer
Service. If the complaint is not valid according to the applicable contract, a staff representative
will contact you or your authorized representative to explain the Plan’s position. If the concern
is valid according to the applicable contract, a staff representative will inform you or your
authorized representative of the corrective action that will be taken and initiate the
appropriate steps to implement the action. Complaint determinations will be made within 30
days of receipt of the complaint.

If You Wish to Appeal an Adverse Administrative Decision

Level I Appeals
Level I Appeals must be received within 180 days of the date you receive written notification
of the denial or of the incident that gave rise to the appeal of the Adverse Administrative
Decision. These appeals should be sent to the Appeals Coordinator at the following address:

Southern Health Services, Inc.
Attention: Appeal Coordinator
9881 Mayland Drive
Richmond, VA 23233

The appeal must include:

- Your name;
- Your provider’s name;
- The date of service;
- Your or your authorized representative’s mailing address;
- An explanation of why the Claims Administrator should consider reversing the original
decision; and
• A copy of any information that will support your request.
• A letter notifying you that the appeal has been received will be sent within five days of its receipt.

A First Level Appeal Committee will review appeals of Adverse Administrative Decisions. The First Level Appeal Committee consists of one or more senior managers of the Claims Administrator. None of these individuals will have been involved in the initial decision. The First Level Appeal Committee will make determinations based upon applicable contract requirements. If the appeal is a Pre-service Appeal, you or your authorized representative will be notified of the First Level Appeal Committee’s decision within 15 days of the date the Claims Administrator received the appeal request. If the appeal is a Post-service Appeal, you or your authorized representative will be notified of the First Level Appeal Committee’s decision within 30 days of the date the Claims Administrator received the appeal request.

Level II Appeals
For both Pre-service Appeals and Post-service Appeals of Adverse Administrative Decisions, if you are not satisfied with the Level I appeal decision, you or your authorized representative may request a Level II appeal within 31 days of the date you received the notice of the Level I appeal decision.

The request must be in writing and include:

• Your name;
• Your provider’s name;
• The date of service;
• Your or your authorized representative’s mailing address;
• An explanation of why the Claims Administrator should consider reversing the original decision; and
• A copy of any information that will support your request.

If you are dissatisfied with the resolution of the Level I appeal, you may request in writing a hearing before the Second Level Appeal Committee. The Second Level Appeal Committee is comprised of one or more members of the Claim Administrator’s executive staff, which includes the CEO, Vice Presidents, Medical Director, or a Plan physician consultant. You have the option to meet in person with the Second Level Appeal Committee or via phone or to have the case reviewed from the available written documentation. In addition, you have the option to appoint a practitioner or your representative to act on your behalf. For Pre-service Appeals, Level II appeal hearings will be held and decision letters sent within 15 days of the date the Claims Administrator received the second level appeal request. For Post-service Appeals, Level II appeal hearing will be held and decision letters sent within 30 days of the date the Claims Administrator received the second level appeal request. In both cases, decision letters will be sent no later than five days after the decision was made. This level constitutes the final attempt at resolution within the Claim Administrator's Member Administrative Complaint and Appeal Procedures.
Decisions Involving Utilization Review
In cases where an Adverse Decision is rendered, the medical aspect of the decision will be reviewed to determine Medical Necessity. Decisions relating to coverage of medical, surgical, or other health care procedures, services, or supplies considered to be Experimental or Investigational are also treated as Medical Necessity determinations. To assist in making a Medical Necessity determination, the Claims Administrator has developed standards and criteria that are objective, clinically valid, and compatible with established standards of health care. Your compliance with any portion of the utilization review process is not a guarantee of benefits or payment.

Reconsideration of an Adverse Decision
If you are dissatisfied with an Adverse Decision, you or your authorized representative, including the treating provider, may request Reconsideration of the Adverse Decision. A request for Reconsideration is optional. You or your authorized representative, including the treating provider, may choose to skip this step and directly appeal an Adverse Decision. Should you choose a Reconsideration of an Adverse Decision, you still have a right to appeal as described below.

Requests for Reconsideration must be received from you, your provider, or your authorized representative within 90 days of the date you or your authorized representative received written notification of the denial or of the incident that gave rise to the initial Adverse Decision. The request for Reconsideration should be sent to the address in the Level I Appeal section above.

If you or your authorized representative chooses to request a Reconsideration of a Medical Necessity determination, a decision is made by either the Claim Administrator’s Medical Director, a Physician Advisor, a peer of the treating provider who is licensed in that provider’s same or similar specialty, or a panel of other appropriate health care providers with at least one Physician Advisor or peer of the treating health care provider on the panel. Notice of the decision will be provided to both you and your authorized representative and your provider in writing within two working days of the decision, but no longer than 10 working days following the Claim Administrator’s receipt of the request. This notification will include the criteria used in making the decision, the clinical reason for the Adverse Decision, alternate length of treatment of any alternate treatment recommended, and the ability to appeal this decision.

Appeal of an Adverse Decision
If you are not satisfied with the Claim Administrator’s Adverse Decision or with the outcome of the Reconsideration, you or your authorized representative may request an appeal within 180 days of the date you received the notice of the Adverse Decision. The request must be in writing and include:

- Your name;
- Your provider’s name;
- The date of service;
- Your or your authorized representative’s mailing address;
- An explanation of why the Claims Administrator should consider reversing the original decision; and
- A copy of any information that will support your request.
The appeal will be reviewed by a panel that includes a Physician Advisor or peer of the treating provider who is licensed in that provider’s same or similar specialty. A Physician Advisor or peer may decide appeals at this level if the Physician Advisor: (i) did not take part in any of the previous levels; (ii) is not employed by nor a director of Southern Health; and (iii) is either licensed in Virginia as a peer of the treating provider or under comparable law in a state within the United States as a peer of the treating provider.

For Pre-service Appeals, you or your authorized representative and the treating provider will be notified of the results of this review within thirty 30 days of the date the Claim Administrator received the request for the appeal.

For Post-service Appeals, you or your authorized representative and the treating provider will be notified of results of this review within 60 days of the date the Claims Administrator received the request for the appeal.

Any final Adverse Decision will state the criteria used in and the clinical reason for the decision. The Member has the right to request the criteria, which will be provided to you.

**Expedited Appeals**

When appropriate, you or your authorized representative including the treating provider may request an Expedited Appeal. The Claims Administrator will immediately notify you or your authorized representative of the decision to deny a request for Expedited Appeal of an Adverse Decision by telephone, facsimile, or electronic mail.

Notification will also include a discussion of the right to file a request for an expedited appeal of an Adverse Decision with the Independent External Review organization. This electronic notification will be followed within 24 hours by written notice of the decision and the right to file a request for an expedited appeal of an Adverse Decision with the Independent External Review Organization.

If the Claims Administrator determines that it will consider the Expedited Appeal, the decision will be made within one working day after receipt of all information needed to make the decision, and no later than 72 hours of the time of the request regardless of whether or not all required information has been received. However, a case relating to prescriptions for the alleviation of cancer pain shall be determined in 24 hours or less from the time of the request. An Adverse Decision through the expedited process may be appealed further through the standard appeal process as described above.

**External Review**

If you receive an adverse decision on appeal, then you may appeal the Adverse Decision to the University of Virginia Health Plan Ombudsman for an external review. You must file a written request to the Ombudsman no later than 30 days after you receive the written notice of denial from the Claims Administrator’s review panel. Your request for external review should state the reasons on which the request is based and should include all appropriate medical records. Letters should be sent to:
UVa Health Plan Ombudsman
University Human Resources Benefits Division
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127.87

The external review organization will render a written decision on the appeal promptly, but not later than 30 days after it receives all necessary information. In its written response to the review, the external review organization will state the reasons for its decision.

FILING COMPLAINTS AND APPEALS FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE

Complaints and appeals regarding Mental Health/Substance abuse services are processed differently than other services.

To file a complaint or appeal regarding mental health and substance abuse services, call the Mental Health toll-free number on your UVA Health Plan ID card.

Complaints and Appeals can also be filed by mailing a letter to the following address:

United Behavioral Health
Attn: Appeals/Complaints
PO BOX 411517
Saint Louis, MO 63141-3517
Telephone: 1-800-975-8919
Facsimile: 1-866-209-9317

External Review

If the decision remains unfavorable and the complaint or appeal addresses medical decisions, the participant may file a written request for external review no later than 30 days after you received written notice of denial from the Claims Administrator’s Mental Health review panel.

You may appeal the Adverse Decision to the University of Virginia Health Plan Ombudsman for an external review. You must file a written request to the Ombudsman no later than 30 days after you receive the written notice of denial from the Claims Administrator’s review panel. Your request for external review should state the reasons on which the request is based and should include all appropriate medical records. Letters should be sent to:

UVa Health Plan Ombudsman
University Human Resources Benefits Division
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127

The external review organization will render a written decision on the appeal promptly, but not later than 30 days after it receives all necessary information. In its written response to the review, the external review organization will state the reasons for its decision.
Filing Complaints and Appeals for Prescription Drug Coverage

Filing a Level 1 Complaint/Appeal
Complaints and appeals regarding Pharmacy Services are processed differently than other services. To file a complaint or appeal regarding pharmacy services, you must file a written appeal within 180 days of receipt of the adverse Benefits determination.

Complaints and appeals can be filed by mailing a letter to the following address:

CVS CAREMARK
Clinical Department-Appeals Process 1
620 Epsilon Drive
Pittsburgh, PA 15238-2845

CVS CAREMARK will complete its review and issue a written response to the member within 30 days of receipt of the written Level 1 Appeal.

Level 2 Appeal
If the decision remains unfavorable, the Participant may file a written request for a Level 2 Appeal. The request must be in writing and indicate that the member is filing a Level 2 Appeal.

The written Level 2 appeal should be sent to:

CVS CAREMARK
Clinical Department-Appeals Process 2
620 Epsilon Drive
Pittsburgh, PA 15238-2845

The written appeal must be filed within 180 days or receipt of the Level 1 decision. CVS CAREMARK will complete its review and issue a written response to the member within 30 days of receipt of the written Level 2 Appeal.

External Review
If you receive an Adverse Decision on a Level 2 appeal, then you may appeal the Adverse Decision to the University of Virginia Health Plan Ombudsman for an external review. You must file a written request to the Ombudsman no later than 30 days after you receive the written notice of denial from the Claims Administrator’s review panel. Your request for external review should state the reasons on which the request is based and should include all appropriate medical records. Letters should be sent to:

UVa Health Plan Ombudsman
University Human Resources Benefits Division
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127.
The external review organization will render a written decision on the appeal promptly, but not later than 30 days after it receives all necessary information. In its written response to the review, the external review organization will state the reasons for its decision.

**FILING COMPLAINTS AND APPEALS FOR DENTAL COVERAGE**

Complaints and appeals regarding Dental Care are processed differently than other services. To file a complaint or appeal regarding dental care, call the toll-free Customer Service number on your University of Virginia Dental ID Card within 180 days of receipt of the adverse Benefits determination.

Complaints and appeals can also be filed by mailing a letter to the following address:

United Concordia  
P.O. Box 69420  
Harrisburg, PA 17110.

The Claims Administrator will review the claim and notify the Participant of its decision within 60 days of the request for appeal.

**External Review**

If the decision remains unfavorable and the complaint or appeal addresses medical decisions, the Participant may file a written request for an external review no later than 30 days after he receives the written notice of denial from the Claims Administrator's review panel. You may appeal the Adverse Decision to the University of Virginia Health Plan Ombudsman for an external review. You must file a written request to the Ombudsman no later than 30 days after you receive the written notice of denial from the Claims Administrator's review panel. Your request for external review should state the reasons on which the request is based and should include all appropriate medical records. Letters should be sent to:

UVa Health Plan Ombudsman  
University Human Resources Benefits Division  
914 Emmet Street  
P.O. Box 400127  
Charlottesville, VA 22904-4127.

The external review organization will render a written decision on the appeal promptly, but not later than 30 days after it receives all necessary information. In its written response to the review, the external review organization will state the reasons for its decision.
Privacy of Health Information

HIPAA Notice of Privacy Practices for the UVa Health Plan and Flex Spending Accounts
Notice of University of Virginia Health Plan’s and the University of Virginia Flexible Spending Account Plan’s (Medical Reimbursement Account Portion) Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNIVERSITY OF VIRGINIA’S PLANS’ COMMITMENT TO PRIVACY

The University of Virginia Health Plan, and the medical reimbursement account portion of the University of Virginia Flexible Spending Account Plan (jointly referred to as the “Plan”) are committed to protecting the privacy of your protected health information. Protected health information, which is referred to as “health information” in this Notice, is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. The Plan creates, receives, and maintains your health information when it provides health, dental, prescription drug, and medical flexible spending account benefits to you and your eligible dependents. The Plan also pledges to provide you with certain rights related to your health information.

By this Notice of Privacy Practices (“Notice”), the Plan informs you that it has the following legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the related regulations (“federal health privacy law”):

- to maintain the privacy of your health information;
- to provide you with this Notice of its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice currently in effect.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, “you” or “yours” refers to insured participants and eligible dependents.

This Notice is effective as of April 14, 2003, and will remain in effect unless and until the Plan issues a revised Notice.

INFORMATION SUBJECT TO THIS NOTICE

The Plan creates, receives, and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan’s administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers, insurance companies, and other third parties. The health information the Plan has about you includes, among other things, your name,
address, phone number, birthdate, social security number, and medical and health claims information. This is the information that is subject to the privacy practices described in this Notice.

This Notice does not apply to health information created, received, or maintained by the University of Virginia on behalf of the non-health employee benefits that it sponsors, such as disability benefits and life insurance benefits. This Notice also does not apply to health information that the University of Virginia requests, receives, and maintains about you for employment purposes, such as employment testing, or determining your eligibility for medical leave benefits or disability accommodations.

**SUMMARY OF THE PLAN’S PRIVACY PRACTICES**

**The Plan’s Uses and Disclosures of Your Health Information**

Generally, you must provide a written authorization to the Plan for it to use or disclose your health information. However, the Plan may use and disclose your health information without your authorization for the administration of the Plan and for processing claims. The Plan also may use and disclose your health information without your authorization for other purposes as permitted by the federal health privacy law, such as health and safety, law enforcement or emergency purposes. The details of the Plan’s uses and disclosures of your health information are described below.

**Your Rights Related to Your Health Information**

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- File a complaint with the Plan or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

**Changes in the Plan’s Privacy Practices**

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

**Contact Information**

If you have any questions or concerns about the Plan’s privacy practices or about this
Notice, if you wish to obtain additional information about the Plan’s privacy practices, or if you wish to submit a complaint, please contact:

UVa Health Plan Ombudsman  
914 Emmet Street  
P.O. Box 400127  
Charlottesville, VA 22904-4127  
434-924-4346

**Detailed Notice of the Plan’s Privacy Policies**

**The Plan’s Uses and Disclosures**

Except as described in this section, as provided for by federal health privacy law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and the processing of health claims. The uses and disclosures that do not require your written authorization are described below.

**Uses and Disclosures for Treatment, Payment, and Health Care Operations**

1. **For Treatment.** The Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you. The Plan does not anticipate making disclosures “for treatment” purposes. However, if necessary, the Plan may make such disclosures without your authorization.

2. **For Payment.** The Plan may use and disclose your health information without your authorization so that your claims for health care services can be paid according to the Plan’s terms. For example, the Plan may use and disclose your health information to determine whether certain health care services that you seek are covered by the Plan or to process your health care claims. The Plan also may disclose your health information to coordinate payment of your health care with others who may be responsible for certain costs.

3. **For Health Care Operations.** The Plan may use and disclose your health information without your authorization so that it can operate efficiently and in the best interests of its participants. For example, the Plan may disclose your health information for underwriting purposes, for business planning purposes, or to attorneys who are providing legal services to the Plan.

**Uses and Disclosures to Business Associates**

The Plan may disclose certain of your health information without your authorization to its “business associates,” which are third parties that assist the Plan in its operations. For example, the Plan may share your claims information with a business associate that provides claims processing services to the Plan, and the Plan may disclose your health information to its business associates for actuarial projection and audit purposes, and legal services. The Plan enters contracts with its business associates to ensure that the privacy your health information is protected.
Uses and Disclosures to the Plan Sponsor
The Plan may disclose your health information, without your authorization, to the Plan Sponsor, which is the University of Virginia, for plan administration purposes, such as performing quality assurance functions, and for monitoring and auditing functions. The Plan Sponsor will certify to the Plan that it will protect the privacy of your health information and that it has amended the plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization
The federal health privacy law provides for specific uses or disclosures of your health information that the Plan may make without your authorization, which are described below.

1. **Required By Law.** The Plan may use and disclose health information about you as required by the law. For example, the Plan may disclose your health information for the following purposes: for judicial and administrative proceedings pursuant to legal process and authority; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury, or disability.

3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigations licensure, and other oversight activities.

4. **Active Members of the Military and Veterans.** Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans’ affairs.

5. **Workers’ Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers’ Compensation benefits.

6. **Emergency Situations.** Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

7. **Others Involved In Your Care.** In limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are involved in your care or payment of your care. For example, your health information may be so disclosed if you are seriously injured and unable to discuss your case with the Plan. Also, in certain instances, the Plan may advise a family member or close personal friend about your general condition, location (such as in the hospital), or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. **Personal Representatives.** Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a relationship with you that
gives them the right to act on your behalf. Examples of personal representatives are parents for minors and those who have Power of Attorney for adults.

9. **Treatment and Health-Related Benefits Information.** The Plan and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services, and medication.

10. **Research.** Under certain circumstances, the Plan may use or disclose your health information for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

11. **Organ and Tissue Donation.** If you are an organ donor, the Plan may use or disclose your health information to an organ donor or procurement organization to facilitate an organ or tissue donation transplantation.

12. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

**USES AND DISCLOSURES FOR FUNDRAISING AND MARKETING PURPOSES**

The Plan does not use your health information for fundraising or marketing purposes.

**ANY OTHER USES AND DISCLOSURES REQUIRE YOUR EXPRESS WRITTEN AUTHORIZATION**

Uses and disclosures of your health information other than those described above will be made only with your express written authorization. You may revoke your authorization in writing. If you do so, the Plan will not use or disclose your health information authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization.

Once your health information has been disclosed pursuant to your authorization, the federal health privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plan’s knowledge or authorization.

**YOUR HEALTH INFORMATION RIGHTS**

You have the following rights regarding your health information that the Plan creates, receives and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

UVa Health Plan Ombudsman
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127
434-924-4346
Right to Inspect and Copy Health Information
You have the right to inspect and obtain a copy of your health information that is maintained by the Plan. This includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy health information maintained by the Plan, submit a written request to the UVa Health Plan Ombudsman. The Plan may charge a fee for the cost of copying and/or mailing the health information that you have requested. In limited instances, the Plan may deny your request to inspect and copy your health information. If that occurs, the Plan will inform you in writing. In addition, in certain circumstances, if you are denied access to your health information, you may request a review of the denial.

Right to Request That Your Health Information Be Amended
You have the right to request that the Plan amend your health information if you believe the information is incorrect or incomplete.

To request an amendment, submit a written request to the UVa Health Plan Ombudsman. This request must provide the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:

- Was not created by or for the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of your health information maintained by or for the Plan;
- Is not part of the health information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures
You have the right to receive a written accounting of disclosures, which is a list of disclosures of your health information by the Plan to others. Generally, the following disclosures are not part of an accounting: disclosures that occur before April 14, 2003; disclosures for treatment, payment, or health care operations; disclosures made to or authorized by you; and certain other disclosures. The accounting covers up to six years prior to the date of your request (but not disclosures made before April 14, 2003).

To request an accounting of disclosures, submit a written request to the UVa Health Plan Ombudsman. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting. The first accounting that you request within a twelve month period will be free. For additional accountings in a twelve month period, the Plan may charge you for the cost of providing the accounting. But, the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw or modify your request before any costs are incurred.
Right to Request Restrictions
You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment, or health care operations. You also have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the UVa Health Plan Ombudsman that explains what information you wish to limit, and how and/or to whom you would like the limits to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location
You have the right to request that the Plan communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plan only contact you at work or by mail, or that the Plan provide you with access to your health information at a specific, reasonable location.

To request confidential communications by alternative means or at an alternative location, submit a written request to the UVa Health Plan Ombudsman. Your written request should state the reason(s) for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of your health information by non-confidential communications could endanger you. The Plan will accommodate reasonable requests and notify you appropriately.

Right to File a Complaint
You have the right to complain to the Plan and/or to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the UVa Health Plan Ombudsman named above.

You will not be retaliated or discriminated against and no services, payment, benefits, or privileges will be withheld from you because you file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice. To make such a request, submit a written request to the UVa Health Plan Ombudsman named above. You may also obtain a copy of this Notice at the Plan’s website, www.hrs.virginia.edu/forms/uvahealthplanprivacy.pdf.

Changes in the Plan’s Privacy Policies
The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including your protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes
any of its privacy practices that are covered by this Notice, it will revise its Notice and provide you with the revised Notice within 60 days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request, and any revised notice will be available at the Plan’s website, www.hrs.virginia.edu.
Miscellaneous Provisions

No Assignment
A Participant cannot assign any Benefits or monies due under this Plan to any person, corporation, organization, or other entity not providing services under the terms of this Plan. Any assignments by a Participant will be void and have no effect. Assignment means the transfer to another person, corporation, organization, or other entity of a Participant’s right to the Benefits provided under this Plan.

Notice
Any notice that UVa or the Claims Administrator gives to a Participant will be in writing and mailed to him or her at the address as it appears on our records. If a Participant has to give UVa or the Claims Administrator any notice, it should be in writing and mailed to the address set forth in the Section titled “General Information.”

Notice of Claim
In order for the Claims Administrator to make payments under this program, the Claims Administrator must receive a Participant's claim for Benefits within 365 days after the Participant receives the service.

Who Receives Payment Under this Plan
Payments under this Plan for Covered Medical Services provided in a Network Hospital or by a Network Physician or Network Provider will be made on UVa's behalf by the Claims Administrator directly to the hospital, physician or provider. If a Participant receives Covered Medical Services in an Out-of-Network Hospital, or from any other Out-of-Network Provider of care covered under the Plan, the Claims Administrator, on UVa's behalf, may pay either the Participant or the hospital or other provider.

Recovery of Overpayments

Benefit Payments
On occasion, a payment may be made on a Participant’s behalf when the Participant is not covered, for a service that is not covered, or in an amount greater than is appropriate for that service. In addition, in some cases the Claims Administrator may have made payment mistakenly, such as, where a Participant had coverage under another health care benefits plan.

When an overpayment of any type has been made, the Claims Administrator will notify the Participant about the overpayment, and when possible, will retract from the provider any payments made in error. The Participant may be responsible for payment to the provider in these cases.

If the Claims Administrator is unable to retract payments from the provider, the Employee-Participant will be contacted by the University Human Resources Benefits Division regarding settlement of the overpaid claim(s). The Employee-Participant will be expected to refund to the University Health Plan within 60 days, the amount of the mistaken payment, or provide the University Health Plan with written notice stating the reasons why the Participant may be entitled to such payment.
The Claims Administrator, acting on the Plan’s behalf, or the Health Plan directly, may also recover the mistaken payment from another health care benefits plan if it has not already received payment from that other plan. The Participant agrees to assist in the recovery of an overpayment or mistaken payment.

To the extent permitted by applicable law, the Claims Administrator, on UVa’s behalf, may reduce future payments to the Participant in order to recover any mistaken payment.

**Required Premiums**

In the event that an Employee-Participant has not paid the full amount of premiums for the coverage selected, whether as a result of a mistake in the amount deducted from wages or for any other reason, then the Employee-Participant must make satisfactory arrangements with UVa for the payment of all required amounts. If no agreement is reached, or if the employee-participant is not in compliance with any aspect of this agreement, then coverage under this plan may be terminated. The employee-participant will be notified prior to termination of coverage.

**Complaint Procedure**

Participants are entitled to have any complaints heard and, under the terms of UVa’s agreement with the Claims Administrator, the Claims Administrator is obligated to hear and resolve such complaints, including complaints against Network Physicians and other Network Providers, in an equitable fashion according to the rules and procedures set forth above in the Section titled “Complaints & Appeals.”

**Review**

If a claim for Benefits is denied, a Participant may obtain a review of the denial through the complaints and appeals procedure described in the Section titled “Complaints & Appeals.”

**Limitation on Benefits of this Plan**

No person or entity other than the Plan Sponsor, the Claims Administrator, and the Participants is or shall be entitled to bring any action to enforce any provision of the Plan against UVa, the Claims Administrator, or the Participants. The covenants, undertakings, and agreements set forth in the Plan shall be solely for the benefit of, and shall be enforceable only by, UVa, the Claims Administrator, and the Participants covered under the Plan.

**Applicable Law**

The Plan, the rights and obligations of UVa, the Claims Administrator, and the Participants under the Plan, and any claims or disputes relating thereto, shall be governed by all applicable state and federal laws. Nothing herein shall be interpreted as a waiver of the sovereign immunity of the Commonwealth of Virginia, nor the assumption of any liability, obligation, or undertaking contrary to law, including the Virginia Tort Claims Act as same shall be in effect from time to time.

**Interpretation of Plan Provisions**

The Claims Administrator shall have the right to interpret the meaning of any description of covered hospital, mental, or dental services included in the Plan, to make factual determinations, and to determine any question which may arise in connection with its application or administration, provided that the Plan Sponsor shall have the exclusive right to interpret the meaning of any description of membership and eligibility rules. The decisions or actions of the Claims Administrator in respect thereof shall be conclusive and binding upon the Employer and
upon any and all Participants, their beneficiaries and their respective heirs, distributees, executors, administrators, and assignees.

Liabilities
By participating in this Plan and seeking the Benefits hereunder, Participants agree and understand that the Rectors, Members of the Board of Visitors ("Board"), Officers, and Employees of the Plan or Plan Sponsor shall not be personally liable for any act or omission taken in good faith discharge of their responsibility in connection with this Plan.

Amendment
UVa shall have the right to amend the Plan from time to time.

Termination
UVa, pursuant to written action of its Board, shall have the right to terminate the Plan at any time by resolution of the Board and written notice to the Claims Administrator.

Program Not an Employment Contract
Nothing contained in this Plan shall be construed as a contract of employment between UVa and any Employee, or as a right of any Employee to be continued in the employment of UVa, or as a limitation of the right of UVa to discharge any of its Employees, with or without cause.

Gender
The masculine whenever used herein shall include the feminine.

Controlling Laws
Construction, validity, and administration of this Program shall be governed by the laws of the Commonwealth of Virginia to the extent not superseded by federal law.
Important Guidelines for the National Network

In order to get the best use of your National Network benefits, please review the following:

**General Guidelines for the National Network**

- Participants in the University of Virginia (UVa) Health Plan who reside outside areas served by the Southern Health (SH) Provider Network need to elect enrollment in the National Network by completing an Out-of-Area form available at the University Human Resources Benefits website or by calling the University Human Resources Benefits Division at 434-924-4392.

- Should you choose to see a provider who does not participate in the appropriate national network (medical, prescription, mental health, or dental), you will have higher out-of-pocket costs and may be required to file claims.

- If you have questions or need assistance, call Southern Health (SH) Customer Service Department at 1-888-975-9557, Monday through Friday, 8:30 a.m. - 5:30 p.m.

- Remember to inform your health care providers of your coverage in the UVa Health Plan’s National Network.

**Network Provider Guidelines**

- The Coventry Health Care National Network is the national network of medical providers available for use to UVa Health Plan participants enrolled in the National Network.

- You may receive medical care from any National Network or SH physician or hospital. A list of participating providers can be found on the ‘Provider Search’ section of the SH website www.southernhealth.com at the Coventry Health Care National Network link.

- You are not required to select a Network Primary Care Physician (PCP) to receive your benefits. However, a relationship with a PCP is important for wellness and general coordination of health care. Therefore, you are encouraged to establish a PCP relationship.

- You do not need a referral to see a participating medical specialist in the National Network.

- You are required to obtain any necessary preauthorization for services. Call SH’s Customer Service Department at 1-888-975-9557 prior to accessing services to determine whether preauthorization is necessary for that particular service.

**Prescription Benefits Guidelines**

- The Prescription Drug Program is administered by CVS Caremark and covers certain medically necessary prescription drugs dispensed by licensed pharmacies. It is a mandatory generic substitution program.

- You may receive prescriptions from any pharmacy in the United States. When you use CVS Caremark participating pharmacies, the pharmacies agree to file claims on your behalf and accept the program allowance as payment in full minus any program deductibles and costsharing. A list of participating pharmacies can be found on CVS Caremark’s website at www.pharmacare.com or by calling CVS Caremark at 1-866-UVA-3707.

- The Formulary Drug List is available on CVS Caremark’s website or the University Human Resources Benefits website or by calling CVS Caremark at 1-866-UVA-3707.

- Generic drug substitution is mandatory (Mandatory Generic) if the FDA has determined a generic to be equivalent to the brand product. If you purchase a brand name medication when a generic equivalent is available, you must pay the cost difference between the brand name drug and the generic drug in addition to the brand name copayment.
• Prior authorization is required for some drugs, including most injectable medications. These are listed in the Formulary Drug List available on CVS Caremark’s website or the University Human Resources Benefits website or by calling CVS Caremark at 1-866-UVA-3707. Please discuss needed prior authorizations with your physician.

• Injectables and Specialty Medications used at home, in the physician's office, and in outpatient settings must be purchased through CVS Caremark Specialty Pharmacy or Retail pharmacy when available. A list of these medications is available at University Human Resources Benefits website or you can call CVS Caremark to find out if your drug is on the specialty list. Patients with complex medical conditions should phone 1-800-621-4786 to enroll with this specialty pharmacy, receive one-on-one support from a patient care coordinator, and have medications delivered directly to the patient’s home or physician’s office.

• Purchasing maintenance drugs through mail order saves you money. If you would like to use CVS Caremark’s mail order service, you will need to complete a mail order enrollment form and submit it with a new prescription from your doctor. CVS Caremark mail order envelopes are available at the University Human Resources Benefits Division or by calling CVS Caremark at 1-866-UVA-3707.

• If you have any questions about Prescription Benefits or need mail order forms or a Formulary List, call CVS Caremark at 1-866-UVA-3707.

**Mental Health Benefits Guidelines**

• The United Behavioral Health Network is the national network of mental health/substance abuse providers available for use to UVa Health Plan participants enrolled in the National Network. A list of participating providers can be found on the ‘Provider Search’ section of the SH website www.southernhealth.com at the Mental Health Provider link.

• For coordination of mental health and substance abuse services, you and/or your provider may call the Southern Health Mental Health line (United Behavioral Health) at 1-800-975-8919.

**Dental Benefits Guidelines**

• United Concordia's National Fee-for-Service Network is the national network of dental providers available for use to UVa Health Plan participants enrolled in the National Network.

• You can receive dental care from any licensed dentist anywhere in the United States. When you use participating providers in the United Concordia National Fee-for-Service Network, the dentists agree to file claims on your behalf and accept program allowances as payment in full minus any program deductibles and copayments.

• Should you choose to see a provider not in the United Concordia Network, you will have higher out-of-pocket costs and may be required to file claims.

• A list of participating dentists can be found on the United Concordia website at www.ucci.com. You may also call United Concordia Customer Service at 1-866-215-2354.

**Vision Benefits Guidelines**

• Under the National Network, you may go directly to an EyeBenefits participating vision provider or vision center to receive discounts on routine eye exams, eyewear, LASIK procedures, Corneal Refractive Therapy (CRT), and mail order contact lenses.

• Call EyeBenefits Customer Service at 1-800-621-7900 or visit www.eyebenefits.com for a list of participating vision providers.
UVa Health Plan Guidelines

- Participants with questions about the National Network can contact the UVa Health Plan Ombudsman by email at healthplanombuds@virginia.edu or by phone at 434-924-4392.
- The Ombudsman is available to explain the UVa Health Plan policies and benefit coverages, investigate payment problems for claims submitted to the UVa Health Plan, listen to complaints and concerns about the health plan and facilitate the appeals process if necessary.

HIPAA Notice of Privacy Practices for the UVa Health Plan

A copy of the HIPAA Notice of Privacy Practices for the UVa Health Plan can be found at the University of Virginia Human Resources Benefits website http://www.hrs.virginia.edu/benefits.html or by contacting the University Human Resources Benefits Division at 434-924-4392.
Definitions

The capitalized words or terms that are used in this Plan Document that are not otherwise defined have the meanings set forth below:

“Adverse Decision” An Adverse Decision is a utilization review determination by the Claims Administrator that the health care service rendered or proposed to be rendered was or is not Medically Necessary, when such determination may result in noncoverage of the health care service. A final Adverse Decision is a type of Adverse Benefit Determination that may result in an Independent External Review.

“Allowable Amount” means the amount the Claims Administrator will pay for any covered service before any applicable cost sharing features, such as Copayments, Coinsurance, or Deductibles. If a Network Provider provides the Covered Medical Service, this Allowable Amount will reflect the fee arrangements that have been agreed upon between this Network Provider and the Claims Administrator and the Participant will not be responsible for amounts billed above the Allowable Amount. If an Out-of-Network Provider provides the Covered Medical Service, the Provider can demand that you pay any amounts over the Allowable Amount in addition to Copayments, Coinsurance, or Deductibles. This is called “balance billing.” The Allowable Amount for Out-of-Network Providers may be different than the Allowable Amount for Network Providers. Consult the Claims Administrator for details.

“Active Work” means the active performance of all of a Participant’s normal job duties at UVa.

“Benefits” means reimbursement or payments for health care available to Participants under the Plan.

“Biologically Based Mental Illness” means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the Participant’s functioning. The following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcohol addiction.

“Coinsurance” means a fixed percentage of charges a Participant must pay toward the cost of Covered Medical Services. The Coinsurance amount is listed in the Schedule of Benefits.

“Copayment” means a fixed dollar amount that a Participant must pay each time he receives a particular Covered Medical Service. See the Schedule of Benefits for a list of those Services that require Copayments.

“Covered Medical Services” means Medically Necessary services for which Benefits are available (i.e., payments will be made) under the Plan. Covered Medical Services do not include services and care excluded under the Section titled “Exclusions” or which do not meet the definition of “Medically Necessary” in this Section.

“Deductible” means a fixed dollar amount that a Participant must incur before the Claims Administrator begins to pay for the cost of Covered Medical Services provided to a Participant during each calendar year. The Deductible amount for each Participant is shown in the Schedule of Benefits.

“Designated Provider” means the following duly licensed providers: hospitals, physicians, physical therapists, speech pathologists, doctors of osteopathy, doctors of podiatry, and duly licensed practitioners who provide services under the supervision of a physician, such as: audiologists, dietitians, nutritionists, nurses (including nurse-practitioners, nurse-midwives, and nurse-anesthetists), and physician assistants. There are certain practitioners (such as acupuncturists, electrologists, and optometrists) whose services the Plan will generally not cover; thus, these practitioners are not considered Designated Providers.
“Employee” means an individual who is employed by the Plan Sponsor.

“Enrollment Application” means the form to be accurately completed by prospective Participants when they apply for enrollment under the Plan. An Enrollment Application is available from the Plan Sponsor.

“Episode of Care” means the course of treatment evidenced by a particular diagnosis and accompanied by distress or impairment, or the presence of a diagnosis for which treatment is required to preserve appropriate symptom relief and functioning. The episode shall be considered complete when there is evidence of substantive improvement in symptoms and functional impairments so that it no longer meets medical necessity criteria for treatment. A new Episode of Care will be triggered by (a) a gap of 90 days or more after the last visit to the provider or his backup providers or after the last service referred by the provider, or (b) evidence of a new and separately identifiable diagnosis requiring treatment.

“Experimental/Investigative Procedures” means investigative or experimental procedures or treatments which are those procedures or treatments that may be utilized by selective physicians, often under investigative protocols, which have yet to be accepted or recognized by the medical community at large as beneficial or necessary. All determinations of whether procedures or treatments are experimental or investigative for purposes of this Plan will be made by the Claims Administrator or their designee, under guidelines it has adopted. This includes services or supplies that in the Claims Administrator’s opinion are:

- In the testing stage or early field trials on humans and animals.
- Under clinical investigation by health professionals or are undergoing clinical trials by any governmental agency, including but not limited to the Department of Health and Human Services or the Food and Drug Administration.
- Without final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or have not been approved by the Health Care Financing Administration for coverage by Medicare.
- Generally not recognized as acceptable medical practice.
- Not yet shown to be consistently effective for the diagnosis or care of the Participant’s condition.
- According to the consensus of opinion among experts, in need of further trials or studies to determine maximum tolerated dosage, safety, and/or its efficacy compared with standard treatments.

“Hospital” is defined as a licensed institution that is primarily engaged in providing:
- Inpatient diagnostic and treatment services for surgical and medical patients;
- Treatment and care of injured and sick persons by or under the supervision of physicians; and
- 24-hour nursing service by or under the supervision of registered nurses.

“Lifetime Maximum” Benefits under the Plan are limited to the amount shown on the Schedule of Benefits. Additional Benefits provided, such as dental care, may have separate lifetime maximums.

“Maximum Out-of-Pocket For Coinsurance” Under the High and Low Premium Programs, Out-of-Pocket expense for Coinsurance is limited each calendar year to the maximum stated in the Schedule of Benefits. After a Participant has paid that amount for Coinsurance, then no additional payments for Coinsurance are necessary during the remainder of that year within that Benefit Option. Deductibles, charges over Allowable Amount, and Copayments do not count toward this Limitation on Out-of-Pocket expenses.

“Medically Necessary” means services or supplies that meet all of the following criteria in that such services or supplies are:

- Provided for the diagnosis, or direct care and treatment of a medical condition that is (i) not excluded from coverage under the Plan and (ii) determined by the Claims Administrator’s opinion; and
- In the testing stage or early field trials on humans and animals.
- Under clinical investigation by health professionals or are undergoing clinical trials by any governmental agency, including but not limited to the Department of Health and Human Services or the Food and Drug Administration.
- Without final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or have not been approved by the Health Care Financing Administration for coverage by Medicare.
- Generally not recognized as acceptable medical practice.
- Not yet shown to be consistently effective for the diagnosis or care of the Participant’s condition.
- According to the consensus of opinion among experts, in need of further trials or studies to determine maximum tolerated dosage, safety, and/or its efficacy compared with standard treatments.
Administrator, applying its established medical policies and guidelines, to be covered under the Plan;

- Appropriate and necessary for the symptoms, diagnosis, and/or treatment of a covered medical condition; required for a reason other than improving physical appearance;

- Within standards of good medical practice as reflected by scientific and peer medical literature, professional medical specialty organizations, and governmental agencies for the supplies, services, equipment, or facilities for which coverage is requested;

- Not primarily for the convenience of the Participant, his or her family, his or her physician, or other provider; and

- The most cost-effective and appropriate supply, location, or level of service available that can safely be provided.

“Network Hospital” means a hospital that has entered into an agreement with the Claims Administrator to make Covered Medical Services available to Participants.

“Network Provider” means a Network Physician, Network Specialist, hospital or other provider having an agreement with the Claims Administrator to make Covered Medical Services available to Participants.

“Non-Biologically Based Mental Illness” means any mental or nervous condition for which coverage for treatment is provided by the Plan and which is not a Biologically Based Mental Illness.

“Out-of-Network Physician, Hospital or Provider” means a physician, hospital or other provider that has not entered into an agreement with the Claims Administrator to make Covered Medical Services available to Participants.

“Out-of-Network Service” means a Covered Medical Service to a Participant by an Out-of-Network Provider.

“Participant” means a covered Employee (or former Employee) and, if also covered by this Plan, any spouse of a covered Employee (or former Employee) or dependents of the covered Employee (or former Employee) or of the covered Employee’s (or former Employee’s) spouse. See the Section titled “Eligibility.”

“Patient Cost” means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Participant for purposes of a clinical trial. Patient Cost does not include (a) the cost of non-health care services that the Participant may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (b) costs associated with managing the research associated with the clinical trial, or (c) the cost of the investigational drug or device.

“Preauthorization, Preauthorize or Preauthorized” is the set of requirements that a Claims Administrator has in place in order to determine Medical Necessity of certain services or procedures prior to them taking place. Penalties or denial of benefits may be incurred by the Participant if Preauthorization requirements are not met before services are incurred.

“Special Condition” means a condition or disease that is (a) life-threatening, degenerative, or disabling and (b) requires specialized medical care over a prolonged period of time.

“Terminal Illness” is a condition that has been diagnosed as terminal by a licensed physician and the medical prognosis is a life expectancy of six months or less.

“Urgent Care Facility” means a licensed facility that provides medical assistance to treat minor and non-life-threatening emergencies.
UNIVERSITY OF VIRGINIA HEALTH PLAN

SUMMARY OF ADDITIONS/CHANGES/CLARIFICATIONS TO THE PLAN PROVISIONS
EFFECTIVE JANUARY 1, 2009

THIS IS THE PLAN DOCUMENT LANGUAGE FOR CHANGES AND CLARIFICATIONS TO THE
PLAN DOCUMENT

PAGE NUMBERS REFER TO JANUARY 1, 2008 DESCRIPTION OF BENEFITS

SAVE THIS INFORMATION WITH YOUR PLAN DOCUMENTS

Medical Schedule of Benefits on Page 4
Clarify coverage for common communicable diseases under 2D by adding “per CDC guidelines”. This is to clarify age and gender limitations.

Add additional coverage for Medically Necessary Acupuncture #16 on Page 6:
Medically Necessary Acupuncture will be covered as a specialist visit with a maximum number of 20 visits per year.

Add a medical necessity appeal process for Brand name prescriptions, to override Dispense As Written (DAW) penalty when a generic is available, by adding phrase to section #18 on page 7. Clarification is in capital letters:

“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 UNLESS BRAND IS APPROVED BY MEDICAL NECESSITY APPEAL WITH CVS CAREMARK.”

Revise #18 prescriptions drug copays by changing prescription copayments on Page 7
The prescription copayments for generic drugs will decrease to $6 for a 30-day retail supply and $14 for a 90-day mail order supply. The prescription copayments for formulary brands will increase to $24 for a 30-day retail supply and $56 for a 90-day mail order supply. Non-formulary brand copayments will increase to $48 for a 30-day retail supply and $112 for a 90-day mail order supply. Specialty drug copayments will remain unchanged.

Revise Specialty Drugs by adding CVS Caremark Specialty Pharmacy must be used to fill all specialty drug prescriptions.

Dental Schedule of Benefits on Page 10
Add coverage of dental implants on the Dental Schedule of Benefits on page 10 as a Type C dental benefit service.

Eligibility on Page 15
Correct typographical error on Page 15 of the DOB under the last section: “Coverage for a new dependent child already over 23…” by revising the sentence. Revision is in capital letters. Revised sentence should state: “Coverage for a new dependent child already over 23 who is INCAPABLE of self support due to mental or physical disability may be granted if:…..”

Mid-Year Qualifying Events on Page 21
Clarify under Mid-Year Qualifying Event changes, by adding “open enrollment at spouse’s employer” to mid-year qualifying event list at 7th bullet. Clarification is in capital letters: OPEN ENROLLMENT; cost and/or coverage changes in employee’s, dependent or spouses, health plan;”…. 

What Happens… IF YOU DIE on Page 26
Clarify that enrolled survivors of subscribers are also eligible to enroll in their own UVA Health Plan policy after the death of their spouse by adding the following sentences-Clarification is in capital letters:
“Your dependents and/or beneficiaries should call the University Human Resources Benefits Division to report your death. Once the death is reported, the dependents will receive detailed information on benefit continuation. Coverage for any dependents enrolled on YOUR health plan terminates at the end of the month following the month of your death. However, these covered dependents may continue participation UNDER A NEW UVA HEALTH PLAN SURVIVOR POLICY OR through COBRA by making the appropriate payments.

DEPENDENTS HAVE 31 DAYS FROM THE DATE OF YOUR DEATH TO ENROLL IN A NEW SURVIVOR UVA HEALTH PLAN POLICY BY SUBMITTING A UVA HEALTH PLAN ENROLLMENT FORM TO THE BENEFITS DIVISION.

Dependents have 60 days from the receipt of the COBRA package to decide whether or not to continue coverage under COBRA for up to an additional 36 months (refer to the “Continuation of Coverage/COBRA” section for more information). Only dependents enrolled at the time of an Employee’s death can continue coverage through COBRA…”

Continuation of Benefits (COBRA) on Page 31
Clarify under FAST FACTS that dependents who are dropped during Open Enrollment are not eligible for COBRA. Clarify by adding sentences in capital letters:
• You and your dependents may continue your coverage under the Plan through a federal law known as COBRA if your coverage ends due to certain Qualifying Events. DEPENDENTS WHO ARE DROPPED DURING OPEN ENROLLMENT ARE NOT ELIGIBLE FOR COBRA.

• Your children are eligible to continue coverage under COBRA when they no longer meet
the Plan’s definition of “eligible dependent” as defined in the “Eligibility” section. DEPENDENT CHILDREN WHO “AGE OFF” THE HEALTH PLAN WILL AUTOMATICALLY BE TAKEN OFF THE SUBSCRIBER’S PLAN AT THE END OF CALENDAR YEAR DURING WHICH THEY TURN 23 AND WILL BE ELIGIBLE FOR COBRA….

**Medical Services that Require Preauthorization** on Page 42
Modify preauthorization requirements by adding clinical trials and specific CPT codes or HCPCS codes listed on back of pre-authorization list attached. http://www.hrs.virginia.edu/forms/preauthlist.pdf

*The Preauthorization list is subject to change. Contact the third-party administrator for current information.

**Transplant Benefits** on Pages 3, 51 and 53
Clarify that Transplant services are only available within the Coventry Transplant Network by adding section # 7 Transplant Services on page 3 in medical schedule of benefits. Clarify that Transplant services are only available within the Coventry Transplant Network by adding (covered in the Coventry Transplant Network only) to 3rd bullet on Page 51 under Hospital Care Fast facts. Clarification is in capital letters:

- Organ/tissue transplants. (COVERED IN THE COVENTRY TRANSPLANT NETWORK ONLY)

Clarify that Transplant services are only available within the Coventry Transplant Network by adding sentence to 1st paragraph on Page 53 under Transplant Benefits: Clarification is in capital letters

TRANSPLANT BENEFITS WILL ONLY BE COVERED AT COVENTRY TRANSPLANT NETWORK PROVIDERS-THERE ARE NO OUT OF NETWORK BENEFITS AVAILABLE FOR TRANSPLANT SERVICES

**Prescription Drugs** on Page 64, 65
Add a medical necessity appeal process for Brand name prescriptions, to override Dispense As Written (DAW) penalty when a generic is available, by adding phrase to “box” on page 64. Clarification is in capital letters:

“The Plan encourages the use of generic drugs. When the government approves a generic form of a drug, the Plan will only pay the cost of the generic drug. If a generic drug is approved and you elect to have the brand name drug instead, or if your physician does not allow substitutions for brand name drugs, the difference between the cost of the brand name drug and the generic will be your responsibility in addition to the appropriate Copayment for the brand medication, UNLESS BRAND IS APPROVED BY MEDICAL NECESSITY APPEAL WITH CVS CAREMARK.”
Add coverage of injectable vitamins under the prescription drug benefit on page 65 by revising the section called “Drugs that not covered under the 3 tier copayment but maybe available under the discount benefits price structure.”
Clarification is in capital letters:
- NON- INJECTABLE vitamins and diet pills;

Dental Care on Page 68
Add additional coverage for analgesia for members under 7 years old for dental services, by adding new sentence: Clarification is in capital letters
ANALGESIA WILL BE COVERED AS A TYPE B SERVICE FOR PARTICIPANTS UNDER 7 YEARS OLD FOR DENTAL SERVICES WHEN MEDICALLY NECESSARY AND ADMINISTERED IN CONNECTION WITH ORAL SURGERY.

Add coverage of dental implants Pages 67, 68 and on the Dental Schedule of Benefits page 10: Dental implants will be covered as a Type C dental benefit service. The annual maximum benefit for dental services remains $1,500 per person for Type A, Type B, and Type C combined.

Add coverage of dental implants by removing dental implants as last bullet on Page 68 under “Dental Services That Are Not Covered”

Add additional coverage for dental implants under dental benefits by removing dental implants as plan exclusions on Page 68.

What the Plan Does Not Cover on Page 69, 73, 74
Add additional coverage for acupuncture by removing these services as plan exclusions on page 69. New language is in capital letters.

Clarify that non routine required immunizations are not covered by adding phrase “required immunizations” to required examinations section in Plan exclusions on page 73. New language is in capital letters.

“Required Examinations/ REQUIRED IMMUNIZATIONS: Examinations and IMMUNIZATIONS specifically for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses, or examinations before engaging in athletic or recreational activities or attending a school, camp, or other program, unless obtained in the context of the periodic examination described in the Section titled “Medical Services.”

Add additional coverage for rental/purchase of TENS Unit with preauthorization by removing this equipment as plan exclusion on page 74.
Important Guidelines for the National Network on Page 102

Add a medical necessity appeal process for Brand name prescriptions, to override Dispense As Written (DAW) penalty when a generic is available, by adding phrase to “box” on page 102. Clarification is in capital letters:

“Generic drug substitution is mandatory (Mandatory Generic) if the FDA has determined a generic to be equivalent to the brand product. If you purchase a brand name medication when a generic equivalent is available, you must pay the cost difference between the brand name drug and the generic drug in addition to the brand name copayment. UNLESS BRAND IS APPROVED BY MEDICAL NECESSITY APPEAL WITH CV'S CAREMARK.”
Medical Schedule of Benefits on Page 1
Revise # 1 Professional Services in office or outpatient by increasing the office visit copayments for Primary Care Physicians from $15 to $20 and increasing the office visit copayments for Specialists from $30 to $40.

Medical Schedule of Benefits on Pages 1-6
Revise cost sharing costs for the high premium program only by:

- Increasing the in-network inpatient hospital copayment in # 6 from $200 to $300 per confinement.
- Increasing the emergency room visit copayment in # 5 from $75 to $125.
- Increasing the in-network outpatient hospital procedure copayment in # 8 from $75 to $125 per visit.
- Adding a $100 individual/$200 family annual deductible to be applied to all services with a coinsurance in #3, 4, 5, 7, 8, and 17.
- Adding the annual deductible and 10% coinsurance to Outpatient Hospital specialty diagnostic services in # 8 including but not limited to anesthesia, drugs, MRA, MRI, CAT scan, and PET scan from the former $75 copay.
- Adding the annual deductible and 10% coinsurance to some services that were covered at 100% (#7, new # 19). These services include but are not limited to accident, blood administration, cardiac rehab, chemotherapy, outpatient contraceptive services, dental injury, dialysis, outpatient diaphragm services, eye exams for diabetics, health education, infertility testing up to the initial diagnosis, infusion IV therapy, outpatient IUD services, outpatient Norplant services, organ transplant diagnostic services, registered nurse, respiratory therapy, and therapeutic injections. Any drugs associated with these services will also have a deductible and 10% coinsurance.

Revise # 12 Mental Health and Substance Abuse Services by increasing mental health coverage. Inpatient acute care for mental health and substance abuse will no longer be limited on an annual or lifetime basis. Outpatient mental health treatment will no longer be limited on an annual basis.
Add a Preauthorization requirement for all mental health and substance abuse services, including outpatient visits.

Revise #18 Prescriptions Drug copayments on Page 5 by changing to prescription coinsurance and the addition of a $100 annual deductible for brand name prescriptions at a retail pharmacy.

- The prescription copayments for generic drugs will remain the same at $6 for a 30-day retail supply and $14 for a 90-day mail order supply.
- The prescription copayments for brand drugs will move from copayments to coinsurance;
- Add an annual deductible of $100 for brand drugs purchased at a retail pharmacy. After the annual prescription deductible has been applied, the prescription coinsurance for a 30-day retail supply of a formulary brand drug will be 20% of the cost of the drug with a minimum payment of $24 and a maximum payment of $100. A 90-day mail order supply of a formulary brand drug will cost 20% of the cost of the drug with a minimum payment of $56 and a maximum payment of $300.
- The prescription coinsurance for a 30-day retail supply of a non-formulary brand drug will be 20% of the cost of the drug with a minimum payment of $48 and a maximum payment of $100 after the prescription deductible has been applied. A 90-day mail order supply of a non-formulary brand drug will cost 20% of the cost of the drug with a minimum payment of $112 and a maximum payment of $300.
- Coinsurance estimates may be obtained at www.caremark.com/uva. Choose ‘UVA 2010 Plan’ as the plan and click on ‘Check Drug Cost’.”

Revise #18 Specialty Drugs Cost Sharing by changing to prescription coinsurance.

- The prescription copayments for all specialty drugs will move from copayments to coinsurance. A 30-day supply of any specialty drug will be 20% of the cost of the drug with a minimum payment of $50 and a maximum payment of $100.
- All biotech drugs and specialty medications for chronic illnesses on the CVS Caremark Specialty List must be filled through the CVS Caremark Specialty Pharmacy. For more information or to enroll in the CVS Caremark Specialty Pharmacy Program, call CaremarkConnect at 1-800-237-2767.

Dental Schedule of Benefits on Page 10
Add coverage of Smile for Health on the Dental Schedule of Benefits as a Type A or B dental benefit service. Smile for Health maternity and enhanced dental benefits will be covered for those with a diagnosis of maternity, heart disease, stroke, diabetes, and respiratory disease. Benefits depend on the diagnosis and could include an additional cleaning as well as enhanced non-surgical periodontal coverage.

Change to Mental Health/Substance Abuse Provider Network on Pages 11, 79, 80, 88, 103
Revise the Mental Health Provider Network to be used by all UVa Health Plan participants by replacing United Behavioral Health with MHNet. Members should contact MHNet at
1-800-975-8919 to determine if a provider participates with MHNet. If a provider is not participating, MHNet can help members transition care to a network provider. For services received January 1, 2010 or later, members must call MHNet at 1-800-975-8919 for mental health and substance abuse pre-authorization.

**General Plan Information** on Page 79
Add new address for MHNet:
MHNet
PO Box 209010
Austin TX 87820

**MHNet Complaints and Appeals** on Pages 80 and 88
Add new address for MHNet:
MHNet Behavioral Health
Attention: Appeals Coordinator
1211 SR 436, Suite 355
Casselberry, FL 32707
Telephone: (800) 975-8919
Facsimile: (407) 831-0211

**Special Enrollment Rights** on page 22
Revise by adding to Special Enrollment Rights in the last entry. New language is in capital letters:
“Additional Special Enrollment Rights are granted by a federal law known as HIPAA when eligibility is lost for other coverage or when COBRA coverage is exhausted or terminated. Based on these events, you may enroll yourself, your spouse, and/or your dependents who have lost other coverage within 60 days of the event. SPECIAL ENROLLMENT RIGHTS ARE ALSO GRANTED WHEN ELIGIBILITY BEGINS FOR A MEDICAID OR STATE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) PREMIUM ASSISTANCE SUBSIDY. YOU MAY ENROLL YOURSELF AND/OR YOUR DEPENDENTS WHO HAVE GAINED ELIGIBILITY WITHIN 60 DAYS OF THE EVENT. The coverage for these Special Enrollments is effective the first of the month following receipt of the enrollment application at the University Human Resources Benefits Division.”

**Medical Services that Require Preauthorization*** on Page 42
Modify preauthorization requirements by adding all Behavioral Health and Substance Abuse Services: inpatient or outpatient Behavioral Health services or Substance Abuse treatment or rehabilitation and all services found on 2010 pre-authorization list attached. * The Preauthorization list is subject to change. Contact the third-party administrator for current information.
[http://www.hrs.virginia.edu/forms/preauthlist.pdf](http://www.hrs.virginia.edu/forms/preauthlist.pdf)

**Obstetrical Services** on Page 46
Clarify that there is no coverage for home births whether or not in the participants’ home or another person’s home.

Second Opinion on page 47
Clarify that second opinions are covered as a specialist visit by removing “under the following conditions” in the first sentence and the following 2 bulleted paragraphs. New language for this section is in capital letters:
“IF YOU REQUEST A SECOND OPINION, THE PLAN WILL PROVIDE COVERAGE FOR A SECOND OPINION OR PROPOSED SURGERY OR TREATMENT.” (end of section)

Prescription Drugs on Page 63, 64, 65
• Clarify under Fact Facts under the 4th bullet regarding specialty drugs and injectables that members are required to obtain Specialty prescription drugs and injectables under the Pharmacy benefit. New language is in capital letters:

Specialty prescription drugs and injectables are covered under the Pharmacy benefit. Participants are REQUIRED to use the Prescription Drug Claims Administrator’s Specialty Pharmacy to order these drugs and have them delivered to the home, physician office, or any other requested location.

• Revise “What You Need To Do” by changing the three occasions when the word “Copayment” is used as indicated in capital letters:

* The COSTSHARING AMOUNT for covered drugs purchased through participating retail pharmacies and the mail order program are shown in the Schedule of Benefits.
* Be aware of COSTSHARING AMOUNTS. The lowest cost is obtained by using generic drugs.
* . . . Although you will still pay 100% of the cost, YOUR cost will be less than the retail cost in most cases.

• Revise “How the prescription drug plan works” by replacing with language in capital letters:
The Plan has FOUR TIERS based on the type of drug. The types of drug are listed below. For actual COST SHARING AMOUNTS, refer to the Schedule of Benefits.

• Generic
• Brand formulary
• Brand non-formulary
• SPECIALTY

 . . . If a generic drug is approved and you elect to have the brand name drug instead, or if your physician does not allow substitutions for brand name drugs, the difference between the cost of the brand name drug and the generic will be your
responsibility in addition to the appropriate COST SHARING AMOUNT for the brand medication.

- Revise “How To Fill Your Prescription” by replacing with new language in capital letters:

  **Participating Pharmacy**
  When you fill a prescription at a pharmacy that participates in the prescription drug network, you just present your ID card when you request your medication. You will pay your COST SHARING AMOUNT and receive your medication.

  **Non-Participating Pharmacy**
  If you fill your prescription at a Non-Participating Pharmacy or a Participating Pharmacy without presenting your valid ID card, you must pay the full cost of your prescription then file a paper claim with the Pharmacy Benefit Manager for reimbursement up to the Allowable Amount, less the applicable COST SHARING AMOUNT. You will pay the difference between the Allowable Amount and the billed amount as well as the applicable COST SHARING AMOUNT.

  **Mail Order Program.**
  You can save money when you purchase “maintenance medications” through the mail order program. A special mail order COST SHARING AMOUNT applies for up to a 90-day supply of maintenance drugs.

- Revise “DRUGS THAT ARE NOT COVERED” by replacing with new language in capital letters:

  **Drugs that are not covered under the FOUR TIERS but may be available under the discount benefit price structure**

**Dental Care** on Page 68

*Add coverage* Smile for Health on the Dental Schedule of Benefits as a Type A or B dental benefit service. **Smile for Health** maternity and enhanced dental benefits will be covered for those with a diagnosis of maternity, heart disease, stroke, diabetes, and respiratory disease. Benefits depend on the diagnosis and could include an additional cleaning as well as enhanced non-surgical periodontal coverage.

**Filing Complaints and Appeals for Mental Health and Substance Abuse Care** on page 88

*Revise to clarify* that complaints and appeals regarding Mental Health/Substance abuse services are processed according to the same process as for medical and hospital claims but are sent to the mental health administrator. New language is in capital letters.

“Complaints and appeals regarding Mental Health /substance abuse service are processed ACCORDING TO THE SAME PROCESS AS MEDICAL AND HOSPITAL CLAIMS.”

**Important Guidelines for the National Network** on Page 103
Revise the mental health benefits guidelines *by replacing* United Behavioral Health Network with MHNet. The Mental Health Provider Network used by all UVa Health Plan participants changed from United Behavioral Health to MHNet. Members should contact MHNet at 1-800-975-8919 to determine if a provider participates with MHNet. If a provider is not participating, MHNet can help members transition care to a network provider. For services received January 1, 2010 or later, members must call MHNet at 1-800-975-8919 for mental health and substance abuse pre-authorization.

Revise Prescription Benefits Guidelines on page 103 *by changing* the telephone number for members to call for more information or to enroll in CVS Caremark Specialty Pharmacy Program to CaremarkConnect at 1-800-237-2767.