

**UNIVERSITY OF VIRGINIA HEALTH PLAN  
MEDICAL SCHEDULE OF BENEFITS  
2009**

	<b>HIGH PREMIUM PROGRAM</b>		<b>LOW PREMIUM PROGRAM</b>	
<b>SERVICES PROVIDED</b>	<b>IN-NETWORK*</b>	<b>OUT-OF-NETWORK**</b>	<b>IN-NETWORK*</b>	<b>OUT-OF-NETWORK**</b>
	<b>Direct Access through SHS network providers</b>	<b>Care provided by non-participating providers</b>	<b>Direct Access through SHS network providers</b>	<b>Care provided by non-participating providers</b>
<b>1. PROFESSIONAL SERVICES IN OFFICE OR OUTPATIENT</b>				
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 1 <sup>st</sup> visit only	Deductible & 25% Coinsurance	\$15 Copayment for 1 <sup>st</sup> visit only	Deductible & 40% Coinsurance
D. Allergy Treatment, Allergy Serum & Allergy Injections	\$15 PCP/\$30 Specialist Copayment	Deductible & 25% Coinsurance	\$15 PCP/\$30 Specialist Copayment	Deductible & 40% Coinsurance
<b>2. PREVENTIVE CARE AND IMMUNIZATIONS</b>				
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 Diagnostic Tests, Laboratory Services and XRay Procedures	Paid in Full	Available In-Network Only	Paid in Full	Available In-Network Only

	HIGH PREMIUM PROGRAM		LOW PREMIUM PROGRAM	
SERVICES PROVIDED	IN-NETWORK*	OUT-OF-NETWORK**	IN-NETWORK*	OUT-OF-NETWORK**
D. For Common Communicable Diseases as per CDC Guidelines (Adenovirus, Diphtheria, Hepatitis B, HPV, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumonia, Poliomyelitis, Rubella, Tetanus, and Varicella) excluding those used for Foreign Travel	Paid in Full (Also considered in-network when performed by university/college student health dept.)	Available In-Network Only	Paid in Full (Also considered in-network when performed by university/college student health dept.)	Available In-Network Only
<b>3. DIAGNOSTIC, LABORATORY AND XRAY PROCEDURES</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
A. Diagnostic Tests, Laboratory Services and XRay Procedures	10% Coinsurance <sup>1</sup>	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance <sup>2</sup>	Deductible & 40% Coinsurance
B. Typical Prenatal Diagnostic Tests, Laboratory Services and XRay Procedures	Paid in Full	Deductible & 25% Coinsurance	Paid in Full	Deductible & 40% Coinsurance
<b>4. URGENT CARE CENTER</b> <i>(Must be an unexpected illness or injury where services are needed sooner than a routine doctor's visit)</i>				
A. Physician Visit	\$30 Copayment	\$30 Copayment	\$30 Copayment	\$30 Copayment
B. Diagnostic Services	10% Coinsurance	10% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
<b>5. EMERGENCY ROOM SERVICES</b> Emergency Room Services will be processed under the Hospital Care Benefits if patient is admitted.				
	<i>(Must be an emergency to receive benefits.)</i>		<i>(Must be an emergency to receive benefits.)</i>	
A. Emergency Room Visit	\$75 Copayment		Deductible & 20% Coinsurance	
B. Emergency Room Physician Services	\$30 Copayment		Deductible & 20% Coinsurance	
C. Diagnostic Services	10% Coinsurance		Deductible & 20% Coinsurance	
<b>6. INPATIENT HOSPITAL</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
A. Inpatient Care (Semi-Private Accommodations Unless	\$200 Copayment per confinement	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance

	HIGH PREMIUM PROGRAM		LOW PREMIUM PROGRAM	
SERVICES PROVIDED	IN-NETWORK*	OUT-OF-NETWORK**	IN-NETWORK*	OUT-OF-NETWORK**
Private Accommodations are Approved for Medical Reasons)				
B. Medically Necessary Intensive Care	Paid in Full	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
C. Limitation on Inpatient Days	Unlimited	Unlimited	Unlimited	Unlimited
D. Other Inpatient Services Including Pre-Admission Testing	Paid in Full	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
<b>7. TRANSPLANT SERVICES</b> Using national transplant network	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
A. Inpatient Services	\$200 Copayment per confinement	Available In-Network Only	Deductible & 20% Coinsurance	Available In-Network Only
B. Diagnostic Tests, Laboratory Services and XRay Procedures	10% Coinsurance	Available In-Network Only	Deductible & 20% Coinsurance	Available In-Network Only
<b>8. OUTPATIENT HOSPITAL</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
A. Outpatient Procedures	\$75 Copayment per visit	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
B. Diagnostic Services (including but not limited to chest xray, EKG, DEXA scans)	10% Coinsurance	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
C. Specialty Diagnostic Services (including but not limited to MRA, MRI, CAT scan, PET scan)	\$75 Copayment per visit	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
<b>9. SKILLED NURSING FACILITY***</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
A. Skilled Nursing / Rehabilitation Facility (180 Days Per Year Combined Maximum)	Paid in Full	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
B. Physician Visit	\$30 Copayment	Deductible & 25% Coinsurance	\$30 Copayment	Deductible & 40% Coinsurance
<b>10. HOME HEALTH SERVICES***</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>

	HIGH PREMIUM PROGRAM		LOW PREMIUM PROGRAM	
SERVICES PROVIDED	IN-NETWORK*	OUT-OF-NETWORK**	IN-NETWORK*	OUT-OF-NETWORK**
Medically Necessary Services Approved By Claims Administrator (90 Visits Per Year Maximum)	Paid in Full	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
<b>11. AMBULANCE TRANSPORTATION</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
Local Ground or Air Transportation When Medically Necessary To and/or From a Hospital	Paid in Full	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
<b>12. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES***</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
A. Inpatient Acute Care for Non-Biologically Based Mental Illnesses (30 Days Per Year Maximum) <i>Lifetime Maximum of 90 Days for Substance Abuse</i>	\$200 Copayment per confinement	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
B. Inpatient Care for Biologically Based Mental Illnesses	\$200 Copayment per confinement	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
C. Outpatient Treatment for Non-Biologically Based Mental Health Illnesses (50 Visits Per Year Maximum)	\$30 Copayment	Deductible & 25% Coinsurance	\$30 Copayment	Deductible & 40% Coinsurance
D. Outpatient Treatment for Biologically Based Mental Illnesses	\$30 Copayment	Deductible & 25% Coinsurance	\$30 Copayment	Deductible & 40% Coinsurance
<b>13. SPEECH THERAPY***</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Maximum)	\$30 Copayment	Deductible & 25% Coinsurance	\$30 Copayment	Deductible & 40% Coinsurance
<b>14. PHYSICAL/OCCUPATIONAL THERAPY***</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>

	HIGH PREMIUM PROGRAM		LOW PREMIUM PROGRAM	
SERVICES PROVIDED	IN-NETWORK*	OUT-OF-NETWORK**	IN-NETWORK*	OUT-OF-NETWORK**
Medically Necessary Restorative Services, Non-developmental Conditions (40 Visits Per Year Combined Maximum)	\$30 Copayment	Deductible & 25% Coinsurance	\$30 Copayment	Deductible & 40% Coinsurance
<b>15. CHIROPRACTIC CARE***</b>				
26 Spinal Manipulations Per Year Maximum, \$600 maximum per year	\$30 Copayment	Deductible & 25% Coinsurance	\$30 Copayment	Deductible & 40% Coinsurance
<b>16. ACUPUNCTURE***</b>				
Medically Necessary Acupuncture Services (20 Visits Per Year Maximum)	\$30 Copayment	Deductible & 25% Coinsurance	\$30 Copayment	Deductible & 40% Coinsurance
<b>17. DURABLE MEDICAL EQUIPMENT</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>	<b>Preauthorization Required</b>
Medically Necessary Equipment, Prosthetic Appliances, and Medical Supplies	20% Coinsurance	Deductible & 25% Coinsurance	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance
<b>18. PRESCRIPTION DRUGS</b>				
For All Covered Medications Requiring a Written Prescription, at Participating Pharmacies (Mandatory Generic Substitution: Coverage is limited to cost of Generic when available)	<p>\$6 (Generic), \$24 (Formulary), and \$48 (Non-Formulary) Copayment per prescription for up to a 30- day supply at Participating Pharmacies only. \$14 (Generic), \$56 (Formulary), and \$112 (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.</p> <p><b>Specialty Drugs:</b> available only in a supply up to 30 days; \$25 (generic), \$50 (Formulary) and \$75 (Non-Formulary) Copayment per prescription. Specialty Drugs must be filled through CVS Caremark Specialty Pharmacy.</p> <p><i>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.</i></p>			
<b>19. MAXIMUM LIFETIME BENEFIT PER PERSON***</b>	\$2,000,000		\$2,000,000	
<b>20. MAXIMUM LIFETIME BENEFIT PER PERSON FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE***</b>	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		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.	

	HIGH PREMIUM PROGRAM		LOW PREMIUM PROGRAM	
SERVICES PROVIDED	IN-NETWORK*	OUT-OF-NETWORK**	IN-NETWORK*	OUT-OF-NETWORK**
<b>21. CALENDAR YEAR DEDUCTIBLE***</b>	(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
<b>22. MAXIMUM OUT-OF-POCKET COINSURANCE***</b>	(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
<b>23. PENALTY FOR FAILURE TO OBTAIN PREAUTHORIZATION</b>	Claim Denial	Claim Denial	Claim Denial	Claim Denial

\* Participants in National Network and Out-of-Area Groups and Exceptions are responsible for obtaining any necessary Preauthorization. Failure to obtain Preauthorization will result in a denial of benefits. Call the Claims Administrator's Customer Service Department prior to accessing services to determine whether Preauthorization is necessary. Claims will be denied entirely if not medically necessary.

\*\* OON cost sharing amounts are based on the Allowable Charge as defined in the Section titled "Definitions" in the Description of Benefits. Participants are responsible for amounts above the Allowable Charge which may be significant. Participants are also responsible for obtaining any necessary Preauthorization when using non-participating providers (Out-of-Network Option). Failure to obtain Preauthorization will result in denial of benefits. Call the Claims Administrator's Customer Service Department prior to accessing services to determine whether Preauthorization is necessary. Claims will be denied entirely if not medically necessary.

\*\*\* The annual and lifetime counters associated with these benefits are reset to zero when a participant moves from one policy to another.

<sup>1</sup> 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.

<sup>2</sup> 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.