

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 CVS CAREMARK .*”