

Value HMO \$20/\$40/20%

\$5,000 In-Network Deductible

Benefit Summary

	In-Network MEMBER PAYS
THERE IS NO DEDUCTIBLE FOR THE FOLLOWING SERVICES WHEN USING AN IN-NETWORK PROVIDER:	
Primary Care Physician or OB/GYN Office Visit (See below for Maternity Services)	\$20 copay
Specialist Office Visit	\$40 copay
Allergy Testing & Treatment	\$20 PCP/\$40 Specialist copay
Allergy Serum & Allergy Injections¹	\$20 PCP/\$40 Specialist copay
Laboratory Services	\$0
Mammograms	\$0
Diagnostic Services (including, but not limited to, chest x-ray, EKG, and DEXA scans)	20% AC ²
Emergency Care	
Hospital Emergency Room Visit (must meet definition of emergency care)	\$250 copay (waived if admitted)
Ambulance Ground Transportation (non-emergency transportation must be preauthorized)	\$100 copay
Urgent Care Visit (must meet definition of urgent care)	\$75 copay
Maternity Services	
Prenatal/postpartum care (after initial office visit copay)	\$0
Inpatient PCP or OB/GYN Provider Charge	\$50 copay
Behavioral Health Care & Substance Abuse Rehabilitation*	
Outpatient Visits 1 - 5 (Maximum 30 visits per benefit year)	\$40 copay per visit or 50% AC; whichever is less
<hr/>	
Benefit Year Deductible (Individual/Family)	\$5,000/\$10,000
A DEDUCTIBLE APPLIES FOR THE FOLLOWING SERVICES:	
You will pay all the costs associated with your care until you have paid your deductible in full.	
Inpatient Hospital Services	20% AC ⁺
Maternity Services	
Inpatient Facility Charge	20% AC ⁺
Outpatient Facility/Outpatient Surgery	20% AC ⁺
Specialty Diagnostic Services (including, but not limited to, MRA, MRI, CAT scan, PET scan, and sleep studies)	20% AC ⁺
Short-Term Rehabilitative Therapy (Occupational, Speech, and Physical Therapy)	
Inpatient (facility) - Maximum 30 days per benefit year	20% AC ⁺
Outpatient Visit - Maximum 30 visits per benefit year	\$40 copay per visit ⁺
Spinal Manipulation - Maximum 10 outpatient visits per benefit year	\$40 copay per visit ⁺
Durable Medical Equipment (DME) and Medical Supplies	20% AC ⁺
Combined maximum of \$2,500 per benefit year for DME and Medical Supplies. Oxygen and diabetes supplies do not count toward this benefit maximum.	
Behavioral Health Care & Substance Abuse Rehabilitation*	
Inpatient Services - Maximum 30 days per benefit year (Up to 10 behavioral health/substance abuse days may be converted to partial days on a basis of 1 inpatient day to 1.5 partial days.)	20% AC ⁺
Outpatient Visits 6 - 30 (Maximum 30 visits per benefit year)	50% AC ⁺
Biologically-Based Mental Illnesses	Covered in the same manner as any other illness or condition ³
Lifetime Maximum Benefit (Per Member)	
Transplant Services	Unlimited
Other Services	Unlimited
Benefit Year Out-of-Pocket Maximum⁴ (Individual/Family)	\$5,000/\$10,000

The Following Services Are Not Covered Under Most Southern Health/CHLIC Benefit Plans

Southern Health/CHLIC does not cover any service or supply that is not medically necessary or that is not a covered service or is a direct result of receiving a non-covered service. In addition the following services are specifically excluded:

- **Administrative Examinations/Immunizations:** exams or immunizations for employment ,travel, school, camp sports, licensing, insurance, adoption, marriage or those ordered by a third party.
- **Administrative Services:** Charges for cancelled appointments, telephone calls, completion of forms, transfer of records, copying of medical records or generation of correspondence.
- **Alternative Medicine** or complementary medicine: includes but is not limited to, hypnotherapy, acupuncture, sleep therapy, behavior training, recreational therapy (dance, arts, crafts, aquatic, gambling and nature therapy), hair analysis, holistic medicine, homeopathy, aroma therapy, massage therapy, herbal, vitamin, or dietary products or therapies
- **Behavioral Health and Substance Abuse:** long term behavioral health care, residential treatment, psychiatric evaluation/therapy related to judicial or administrative proceedings/orders when employer requested or required by school, educational testing or psychological testing, marriage or relationship counseling; vocational or employment counseling, treatment of mental retardation and learning disabilities is not covered under behavioral health and substance abuse benefits
- **Bionic Devices** (electronic enhanced prosthesis) including, but not limited to, C-Leg
- **Blood:** drawing, preparation and storage of umbilical cord blood.
- **Braces** and supports for athletic participation or for employment
- **Charges** in excess of any benefit limitations (e.g., number of days, etc.)
- **Contraceptive** (birth control). Oral or injectable contraceptives unless your employer has elected the prescription drug rider
- **Cosmetic** treatment and/or surgery performed mainly to improve a member's appearance or for psychological benefits
- **Coverage:** Services before the effective date of **coverage** or after the termination date of the member's **coverage** period with Southern Health except as described in the *Evidence of Coverage /Certificate of Insurance (EOC/COI)*
- **Custodial care** including inpatient or outpatient custodial care, nursing home care, respite care, rest cures, domiciliary or convalescent care along with all related services
- **Dental** services or related expenses; oral appliances or devices (e.g., bite guards for teeth grinding, dental implants, dentures, oral appliances for snoring or sleep apnea); treatment of diseases of the teeth or gums except as defined in the *EOC/COI*; oral surgery that is part of an orthodontic treatment program, is required for correction of an occlusal defect, or is not specifically covered in the *EOC/COI*; shortening of the mandible or maxillae for cosmetic or orthodontic purpose; correction of malocclusion, and surgical orthodontics or orthognathices, and soft tissue impactions except as stated in the *EOC/COI*
- **Donor:** Procedures involving member's organ and tissue **donors**, unless the recipient is a covered Southern Health member. Charges for tests and procedures related to **donor** searches.
- **Educational** classes, programs, and support groups including, but not limited to, prenatal courses, marital counseling, self-help training and other non-medical self care and those dealing with lifestyle changes.
- **Experimental/Investigational:** Medical, surgical or other health care procedures that are experimental/investigational as described in the *EOC/COI*
- **Eye:** Routine eye exams; any services for eyeglasses or contact lenses including refraction unless your group has elected the vision rider; services for, or related to, eye surgery to correct refraction (e.g. radial keratotomy, lasik, and laser eye surgeries or vision correction procedures) eye exercises; eye therapy and visual augmentation devices
- **Foot:** Routine **foot** care including trimming of hyper keratotic lesions, calluses, and nails; orthotics, arch supports, corrective shoes, shoe inserts, heel elevations and fittings for such devices
- **Genetic Testing/Counseling:** Parental screening and related genetic counseling for genetic predisposition either before or after conception; pre-implantation genetic testing
- **Growth Hormone:** Growth hormone for idiopathic short stature or for individuals over age eighteen (18) is not covered. Growth hormones are only covered when the group has a prescription drug rider; refer to the rider for specific information.
- **Hearing Aids**
- **Infertility:** Surgical or medical treatment of **infertility**, including services, office visits, lab and diagnostic tests, and procedures to promote conception by artificial means including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination and embryo transfers; human chorionotropin, urofollitropin, menotropins or derivatives; cost of donor sperm, services for sperm collection or sperm preservation
- **Medical Equipment, appliances, devices and supplies** including but not limited to: elastic or leather braces or supports, canes, traction apparatus, cervical collars, corsets, cranial helmets, batteries and battery chargers, exercise equipment, office chairs,air conditioners, filters, humidifiers, dehumidifiers, bedliners, mattress covers, sun or heat lamps, whirlpool baths, heating pads, rental or purchase of TENS units, items for personal hygiene, comfort, or convenience, including but not limited to grab/tub bars, tub benches, breast pumps, telephone, television, guest meals, and accommodations, take home medications, and supplies; home improvement items,

including but not limited to, escalators, elevators, ramps, stair glides and emergency alert equipment; expenses incurred at a health spa, gym or similar facility, office visits for a non-covered device or supply. Over-the-counter medical supplies which do not require a prescription, including but not limited to, Band-Aids, antibiotic cream, Vita lights, and magnetic mats.

- **Newborn** hospital and physician charges during the inpatient stay following birth or any subsequent services when the newborn is not enrolled in the plan within 31 days of birth
- **Nutrition** training except for diabetes education;
- **Nutritional** formula or supplements, tube feeding and medical foods
- **Out-of-Network:** Charges in excess of the Allowable Charge are not covered and will not accrue to the Out-of-Pocket Maximum. (POS and PPO plans only)
- **Pregnancy:** Implantation services for any reason
- **Prescription drugs** (except insulin) unless your group has elected the prescription drug rider
- **Private duty nursing**
- **Private room** unless medically necessary or a semi-private room is not available.
- **Rehabilitation:** Long-term rehabilitation therapy; pulmonary rehabilitation.
- **Research:** Services for medical **research**, unless the services are specifically listed as covered in the *EOC/COI*
- **Services or Supplies:** for injuries sustained during the commission of an illegal act; as a result of a Temporary Detention Order; required by law be treated in a public facility; care for military service connected disabilities for which the member is legally entitled to services when facilities are reasonably available to the member. Services or supplies received before the effective date of coverage or after the termination date of the member's coverage period with Southern Health/CHLIC except as described in the *EOC/COI*. Service and supplies for smoking cessation and nicotine addiction. Services rendered outside the scope of a participating or non-participating provider's license, rendered by a provider with the same legal residence as the Southern Health member, or rendered by a person who is a member of the Southern Health member's family including a spouse, brother, sister, parent, step-parent, child or step-child.
- **Sexual aids**, treatment of **sexual dysfunction**, or **sex transformation** or the reversal thereof. This includes medical and mental health services. Treatment of sexual dysfunction is limited to pharmacologic therapy if your group has elected the prescription drug rider.
- The reversal of **Sterilization**
- **Stockings:** elastic hose, graduated compression (TED) hose, Jobst stockings
- **Travel and Transportation** unless medically necessary and preauthorized
- **Testicular Implants**
- **Therapy:** Physical or Occupational Therapy for the purpose of behavior modification or for improving performance in school or sports; Occupational Therapy for the purpose of treating sensory hypersensitivity; Sensory Integration Therapy
- **Weight** reduction programs; dietary supplements; medical or psychiatric services, office visits or procedures to treat obesity or for **weight** reduction, including but not limited to, gastric bypasses, "mini" gastric bypasses, stomach stapling, gastric balloons, jejunal bypasses, gastric banding, gastroplasty, BPD-DS, and bariatric specialist services
- **Work** related injuries or illnesses eligible for coverage by worker's compensation

** Services for the treatment of Biologically-Based Mental Illnesses, as defined by Southern Health, will be covered. For the purpose of determining benefit year or lifetime durational limits, lifetime episodes or treatment limits, deductibles, copayment and coinsurance factors, and benefit year maximums for deductibles, copayment and coinsurance factors, Biologically-Based Mental Illnesses will be treated the same as any other illness or condition.

Renewability/Termination of Coverage - Coverage for members will renew on an annual basis unless otherwise terminated in the event of, among other things, misuse of your Member ID card, failure to continue to meet eligibility requirements of coverage, group's or Member's failure to pay premium or your failure to pay your payment responsibility for services rendered, your participation in activities which endanger the safety and welfare of Southern Health or its employees or providers, or termination of Southern Health's agreement with your group for any reason. For material misstatements or fraudulent statements in the application process, coverage may be void. If a subscriber's coverage terminates for any reason, termination will be for the subscriber and all covered dependents. You may be able to obtain continuation of coverage or convert to individual coverage. Consult your benefits department or *EOC/COI* for further information.

The benefit payable for each service is 100% unless indicated otherwise. Southern Health's benefit payable is calculated after subtracting from the Allowable Charge any applicable deductible, copayment, coinsurance or penalty owed by the member.

This is only a summary description of benefits, exclusions and limitations that is subject to change. This is not a contract. A complete list of benefits, exclusions and the procedural requirements of the plan can be found in the *EOC/COI (SH.HMO.07, SH.POS.07, SH.PPO.07)*, *SHS.HMOVis.1-05; SHS.POSVis.1-05; CHL.PPOVis.1-05 and Schedule of Benefits (SH.SB.HMO9-06, SH.SB.HMO.5-08, SH.SB.POS.9-06, SH.SB.POS.5-08, SH.SB.PPO.7-07, SH.SB.PPO.HDHP.9-06, SH.SB.VCPO.9-07)*. This material is to be used for informational purposes only.

+ After benefit year deductible paid.

1 If the copay is greater than the amount of the injection, then the member/covered individual will only be charged the cost of the injection.

2 AC (Allowable Charge) - Allowable Charge is the amount that a participating provider has agreed to accept as payment in full pursuant to its agreement with Southern Health/CHLIC. For non-participating providers the Allowable Charge is equal to the out-of-network rate. The out-of-network rate is based on: a defined Virginia Medicare fee schedule, a fixed per diem rate, a St. Anthony's fee schedule or a fixed percentage of billed charges. The type and place of service determines the applicable schedule/rate.

3 Services for the treatment of Biologically-Based Mental Illnesses, as defined by Southern Health/CHLIC, will be covered. For the purpose of determining benefit year or lifetime durational limits; lifetime episodes or treatment limits; deductibles, copayment and coinsurance factors; and benefit year maximums for deductibles, copayment and coinsurance factors, Biologically-Based Mental Illnesses will be treated the same as any other illness or condition.

4 All amounts paid by the member for covered services contribute to the out-of-pocket maximum, with the exception of durable medical equipment, medical supplies, non-implanted prosthetic devices, drugs and self-administered injectables covered under a pharmacy rider, vision services covered under a vision rider, charges in excess of the Allowable Charge, charges paid by the member/covered individual for a non-covered service, and charges in excess of benefit limitations.

* Southern Health/CHLIC contracts with an outside vendor for these services.