<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>MEMBER PAYS</td>
<td>MEMBER PAYS</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$150 copay (waived if admitted)*</td>
<td>$75 copay*</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>$0*</td>
<td>40% AC*</td>
</tr>
<tr>
<td>Short-Term Rehabilitative Therapy</td>
<td>20% AC*</td>
<td>40% AC*</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>20% AC*</td>
<td>40% AC*</td>
</tr>
<tr>
<td>Spinal Manipulation</td>
<td>20% AC*</td>
<td>40% AC*</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>20% AC*</td>
<td>40% AC*</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>20% AC*</td>
<td>40% AC*</td>
</tr>
<tr>
<td>Mental Health Care &amp; Substance Abuse Rehabilitation*</td>
<td>20% AC*</td>
<td>40% AC*</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Unlimited</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
The Following Services Are Not Covered Under Most Southern Health/CHLIC Benefit Plans

1. **All coinsurance and deductibles paid both in-network and out-of-network contribute to the respective out-of-pocket maximum, with the exception of charges in excess of the Allowable Charge, charges assessed to the covered individual as a notification penalty, charges paid by the covered individual for a non-covered service, and charges in excess of benefit limitations (e.g., number of days, etc.).**

2. **Contraceptive (birth control). Oral Contraceptives unless Your employer has elected the prescription drug rider.**

3. **Cosmetic treatment and/or surgery performed mainly to improve a Member’s appearance or for psychological benefits.**

4. **Coverage: Services before the effective date of coverage or after the termination date of the Member’s contract period with Southern Health/CHLIC except as described in the Evidence of Coverage/Contract (EOC/COI).**

5. **Custodial care including inpatient or outpatient custodial care, nursing home care, respite care, rest cures, domiciliary or convalescent care along with all related services.**

6. **Dental services or related expenses; oral appliances or devices (e.g. bite guards for teeth grinding, dental implants or complements, appliances for grazing or not sleeping); 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 maxilla for cosmetic or orthodontic purpose; correction of malocclusion, and surgical orthodontics or orthognathics, removal of soft tissue and muscle restrictions.**

7. **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.**

8. **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.**

9. **Experimental/investigational: Medical, surgical or other health care procedures that are experimental/investigational as described in the EOC/COI.**

10. **Eye: Routine eye exams; any services for eyeglasses or contact lenses including refraction unless Your group elected the vision plan; services related to 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.**

11. **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.**

12. **Genetic Testing/Counseling: Parental screening and related genetic counseling for genetic predisposition either before or after conception; pre-implantation genetic testing.**

13. **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.**

14. **Hearing Aids: Surgery 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, intrauterine insemination, artificial insemination and embryo transfer; human chorionotropin, unfertilized, tropins or derivatives; cost of donor sperm, services for sperm collection or sperm preservation.**

15. **Medical Equipment: appliances, devices and supplies including but not limited to: elastic or leather braces or supports, suction apparatus, cervical collars, corsets, bath 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, telephones, television, guest meals, and accommodations, take home medications, and supplies; home improvement items, including but not limited to, escalators, elevators, ramps, stair glides and other transportation equipment occurred at a health spa, gym or similar facility, office visits for a non-covered device or supply.**

16. **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.**

17. **Nutrition training except for diabetes education.**

18. **Oral appliances or devices (e.g. bite guards for teeth grinding, dental implants or complements, appliances for grazing or not sleeping); 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 maxilla for cosmetic or orthodontic purpose; correction of malocclusion, and surgical orthodontics or orthognathics, removal of soft tissue and muscle restrictions.**

19. **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).**

20. **Pregnancy: Implantation services for any reason.**

21. **Prescription drugs (except insulin) unless Your group has elected the prescription drug rider.**

22. **Private duty nurse unless Medically Necessary or a semi-private room is not available.**

23. **Rehabilitation: Long-term rehabilitation therapy; pulmonary rehabilitation.**

24. **Research: Services for medical research, unless the services are specifically listed as covered in the EOC/COI.**

25. **Robotic: Gastric related to robotics during surgery.**

26. **Services or Supplies: for injuries sustained during the commission of an illegal act; as a result of a Temporary Detention Order; required by law to 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.**

27. **Sexual aids, treatment of sexual dysfunction, or sex transformation or the reversal thereof. This includes medical and mental health services.**

28. **The treatment of Services or Supplies for injuries sustained during the commission of an illegal act; as a result of a Temporary Detention Order; required by law to 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.**

29. **Travel and Transportation unless Medically Necessary and preauthorized.**

30. **Tracheostomy.**

31. **Tinnitus.**

32. **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.**

33. **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, weight loss surgery.**

34. **Work-related injuries or illnesses eligible for coverage by worker’s compensation.**

35. **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 duration 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.**

36. **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.**

37. **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.**

+ After benefit year deductible paid.

1. All coinsurance and deductibles paid both in-network and out-of-network contributed to the respective out-of-pocket maximum, with the exception of charges in excess of the Allowable Charge, charges assessed to the covered individual as a notification penalty, charges paid by the covered individual for a non-covered service, and charges in excess of benefit limitations. Copayments do not apply to the benefit year out-of-pocket maximum.

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 estimated out-of-network rate. This 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. 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.

4. 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 duration 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.

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