

Benefit Summary • Effective January 1, 2012

	Care HMO			Value HMO			
	In-Network Member Pays			In-Network Member Pays			
THERE IS NO DEDUCTIBLE FOR THE FOLLOWING SERVICES							
Preventive Services	\$0			\$0			
Primary Care Physician or OB/GYN Office Visit	\$20 copay			\$25 copay			
Specialist Office Visit	\$40 copay			\$45 copay			
Allergy Testing	\$20 PCP/\$40 Specialist copay			\$25 PCP/\$45 Specialist copay			
Allergy Serum and Allergy Injections	\$10 PCP/Specialist copay			\$25 PCP/\$45 Specialist copay			
Laboratory Services	\$0			\$0			
Mammograms	\$0			\$0			
Diagnostic Services (including, but not limited to, chest x-ray, EKG, and DEXA scans)	\$0			\$0			
Emergency Care - Hospital Emergency Room Visit (must meet definition of emergency care)	\$150 copay (waived if admitted)			\$150 copay (waived if admitted)			
Urgent Care Visit	\$20 copay			\$25 copay			
Maternity Services							
Prenatal/postpartum care (after initial office visit copay)	\$0			\$0			
Inpatient PCP or OB/GYN Provider Charge	\$50 copay			\$50 copay			
Behavioral Health Care & Substance Abuse Rehabilitation							
Outpatient Visits	\$40 copay			\$45 copay			
Short-Term Rehabilitative Therapy (Occupational, Speech, and Physical Therapy)							
Outpatient Rehab	\$25 copay			\$45 copay			
Spinal Manipulation (Maximum 20 outpatient visits per benefit year)	\$40 copay			\$45 copay			
Nutritional Counseling (Maximum 5 visits per benefit year)	\$45 benefit payable per visit			\$45 benefit payable per visit			
Prescription Drug Benefit							
Retail (up to 31 day supply)				\$10 Preferred Generic/\$30 Preferred Brand/\$55 Non-Preferred Brand			
Mail Order (up to 90 day supply)				\$10 Preferred Generic/\$60 Preferred Brand/\$165 Non-Preferred Brand			
A DEDUCTIBLE APPLIES FOR THE FOLLOWING SERVICES: <i>You will pay all the costs associated with your care until you have paid your deductible in full.</i>							
Benefit Year Deductible (Individual/Family)	\$150/\$150			\$150/\$150			
Inpatient Hospital Services	\$200 copay per day up to \$1,000 total per admission			30% AC ¹			
Maternity Services							
Inpatient Facility Charge	\$200 copay per day up to \$1,000 total per admission			30% AC ¹			
Outpatient Facility/Outpatient Surgery	\$200 copay			30% AC ¹			
Specialty Diagnostic Services (including, but not limited to, MRA, MRI, CAT scan, PET scan, and sleep studies)	\$200 copay			30% AC ¹			
Short-Term Rehabilitative Therapy (Occupational, Speech, and Physical Therapy)							
Inpatient (facility) - Maximum 30 days per benefit year	\$200 copay per day up to \$1,000 total per admission			30% AC ¹			
Durable Medical Equipment (DME) and Medical Supplies	\$0			\$0			
Behavioral Health Care & Substance Abuse Rehabilitation							
Inpatient Services	\$200 copay per day up to \$1,000 total per admission			30% AC ¹			
Lifetime Maximum Benefit (Per Member)							
Transplant Services ³	Unlimited			Unlimited			
Other Services	Unlimited			Unlimited			
Benefit Year Out-of-Pocket Maximum (Individual/Family)	\$2,500/\$5,000 ²			\$2,500/\$5,000 ²			
EMPLOYEE HEALTH CARE DEDUCTIONS							
		Monthly	Biweekly	10 Month	Monthly	Biweekly	10 Month
For full and permanent part-time 30 hours or more per week	Employee Only	\$26.80	\$13.40	\$32.16	\$12.24	\$6.12	\$14.69
	Employee + 1 child	\$202.20	\$101.10	\$242.64	\$119.60	\$59.80	\$143.52
	Employee + children	\$404.46	\$202.23	\$485.35	\$279.50	\$139.75	\$335.40
	Employee + spouse	\$301.62	\$150.81	\$361.94	\$197.26	\$98.63	\$236.71
	Employee + family	\$533.20	\$266.60	\$639.84	\$381.10	\$190.55	\$457.32

This is intended as a summary of your benefits only. Please see pages 27-29 for plan exclusions and limitations.

AC - Allowable Charge. See Note 1 on page 31.

In-Network - pertains to a participating provider. If you visit a participating provider, you are using In-Network benefits.

Out-of-Network - pertains to a non-participating provider. If you visit a non-participating provider, you are Out-of-Network. **Only Qualified Emergencies or Urgent Care will be covered.**

¹ See page 29 for explanation

² See page 29 for explanation

³ See page 29 for explanation

* Health Plan pays 70% of AC. You pay 30% of AC, and **you may be subject to balance billing by Out-of-Network providers for amounts in excess of AC.**

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Care POS					
		In-Network Member Pays			Out-of-Network (OON) Member Pays
THERE IS NO DEDUCTIBLE FOR THE FOLLOWING SERVICES WHEN USING AN IN-NETWORK PROVIDER					\$400/\$800 Deductible applies to all OON services
Preventive Services		\$0			\$0
Primary Care Physician or OB/GYN Office Visit		\$25 copay			30% AC ¹⁺
Specialist Office Visit		\$25 copay			30% AC ¹⁺
Allergy Testing		\$25 PCP/Specialist copay			30% AC ¹⁺
Allergy Serum and Allergy Injections		\$10 PCP/Specialist copay			30% AC ¹⁺
Laboratory Services		\$0			30% AC ¹⁺
Mammograms		\$0			30% AC ¹⁺
Diagnostic Services (including, but not limited to, chest x-ray, EKG, and DEXA scans)		\$0			30% AC ¹⁺
Emergency Care - Hospital Emergency Room Visit (must meet definition of emergency care)		\$150 copay (waived if admitted)			
Urgent Care Visit		\$25 copay			
Maternity Services					
Prenatal/postpartum care (after initial office visit copay)		\$0			30% AC ¹⁺
Inpatient PCP or OB/GYN Provider Charge		\$50			30% AC ¹⁺
Behavioral Health Care & Substance Abuse Rehabilitation					
Outpatient Visits		\$25 copay			30% AC ¹⁺
Short-Term Rehabilitative Therapy (Occupational, Speech, and Physical Therapy)					
Outpatient Rehab		\$25 copay			30% AC ¹⁺
Spinal Manipulation (Maximum 20 outpatient visits per benefit year)		\$25 copay			30% AC ¹⁺
Nutritional Counseling (Maximum 5 visits per benefit year)		\$45 benefit payable per visit			
Prescription Drug Benefit					
Retail (up to 31 day supply)		\$10 Preferred Generic/\$30 Preferred Brand/\$55 Non-Preferred Brand			
Mail Order (up to 90 day supply)		\$10 Preferred Generic/\$60 Preferred Brand/\$165 Non-Preferred Brand			
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.					
Benefit Year Deductible (Individual/Family)		\$150/\$150			See deductible above
Inpatient Hospital Services		20% AC ¹			30% AC ¹⁺
Maternity Services					
Inpatient Facility Charge		20% AC ¹			30% AC ¹⁺
Outpatient Facility/Outpatient Surgery		\$200 copay			30% AC ¹⁺
Specialty Diagnostic Services (including, but not limited to, MRA, MRI, CAT scan, PET scan, and sleep studies)		\$200 copay			30% AC ¹⁺
Short-Term Rehabilitative Therapy (Occupational, Speech, and Physical Therapy)					
Inpatient (facility) - Maximum 30 days per benefit year		20% AC ¹			30% AC ¹⁺
Durable Medical Equipment (DME) and Medical Supplies		\$0			30% AC ¹⁺
Behavioral Health Care & Substance Abuse Rehabilitation					
Inpatient Services		20% AC ¹			30% AC ¹⁺
Lifetime Maximum Benefit (Per Member)					
Transplant Services ³		Unlimited			Unlimited
Other Services		Unlimited			Unlimited
Benefit Year Out-of-Pocket Maximum (Individual/Family)		\$2,500/\$5,000 ²			
EMPLOYEE HEALTH CARE DEDUCTIONS		Monthly	Biweekly	10 Month	If you and your spouse are both employed by the County of Henrico, contact your Benefits Office for double contribution rates.
For full and permanent part-time 30 hours or more per week	Employee Only	\$48.60	\$24.30	\$58.32	
	Employee + 1 child	\$239.62	\$119.81	\$287.54	
	Employee + children	\$461.10	\$230.55	\$553.32	
	Employee + spouse	\$348.92	\$174.46	\$418.70	
	Employee + family	\$602.22	\$301.11	\$722.66	

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AC - Allowable Charge. See Note 1 on page 29.

In-Network - pertains to a participating provider. If you visit a participating provider, you are using In-Network benefits.

Out-of-Network - pertains to a non-participating provider. If you visit a non-participating provider, you are Out-of-Network. **Only Qualified Emergencies or Urgent Care will be covered.**

¹ See page 29 for explanation

² See page 29 for explanation

³ See page 29 for explanation

* Health Plan pays 70% of AC. You pay 30% of AC, and **you may be subject to balance billing by Out-of-Network providers for amounts in excess of AC.**

Benefit Summary • Effective January 1, 2012

Value PPO				
		In-Network Member Pays		Out-of-Network Member Pays
Preventive Services		\$0 ⁺⁺		\$0
Benefit Year Deductible (Individual/Family)		\$400/\$800		\$1,000/\$2,000
Primary Care Physician or OB/GYN Office Visit		20% AC ¹		30% AC ¹⁺
Specialist Office Visit		20% AC ¹		30% AC ¹⁺
Allergy Testing		20% AC ¹		30% AC ¹⁺
Allergy Serum and Allergy Injections		20% AC ¹		30% AC ¹⁺
Laboratory Services		20% AC ¹		30% AC ¹⁺
Mammograms		\$0		30% AC ¹⁺
Diagnostic Services (including, but not limited to, chest x-ray, EKG, and DEXA scans)		20% AC ¹		30% AC ¹⁺
Emergency Care - Hospital Emergency Room Visit (must meet definition of emergency care)				20% AC ¹
Urgent Care Visit				20% AC ¹
Maternity Services				
Prenatal/postpartum care (after initial office visit copay)		\$0		30% AC ¹⁺
Inpatient PCP or OB/GYN Provider Charge		\$50 copay		30% AC ¹⁺
Inpatient Facility Charge		20% AC ¹		30% AC ¹⁺
Behavioral Health Care & Substance Abuse Rehabilitation				
Inpatient Services		20% AC ¹		30% AC ¹⁺
Outpatient Visits		20% AC ¹		30% AC ¹⁺
Short-Term Rehabilitative Therapy (Occupational, Speech, and Physical Therapy)				
Inpatient (facility) - Maximum 30 days per benefit year		20% AC ¹		30% AC ¹⁺
Outpatient Rehab		20% AC ¹		30% AC ¹⁺
Spinal Manipulation (Maximum 20 outpatient visits per benefit year)		20% AC ¹		30% AC ¹⁺
Nutritional Counseling (Maximum 5 visits per benefit year)				\$45 benefit payable per visit
Prescription Drug Benefit				
Retail (up to 31 day supply)				\$10 Preferred Generic/\$30 Preferred Brand/\$55 Non-Preferred Brand ⁺⁺
Mail Order (up to 90 day supply)				\$10 Preferred Generic/\$60 Preferred Brand/\$165 Non-Preferred Brand ⁺⁺
Inpatient Hospital Services		20% AC ¹		30% AC ¹⁺
Outpatient Facility/Outpatient Surgery		20% AC ¹		30% AC ¹⁺
Specialty Diagnostic Services (including, but not limited to, MRA, MRI, CAT scan, PET scan, and sleep studies)		20% AC ¹		30% AC ¹⁺
Durable Medical Equipment (DME) and Medical Supplies		20% AC ¹		30% AC ¹⁺
Lifetime Maximum Benefit (Per Member)				
Transplant Services ³		Unlimited		Unlimited
Other Services		Unlimited		Unlimited
Benefit Year Out-of-Pocket Maximum (Individual/Family)		\$2,500/\$5,000 ²		\$3,000/\$6,000 ²
EMPLOYEE HEALTH CARE DEDUCTIONS		Monthly	Biweekly	10 Month
For full and permanent part-time 30 hours or more per week	Employee Only	\$26.80	\$13.40	\$32.16
	Employee + 1 child	\$202.20	\$101.10	\$242.64
	Employee + children	\$404.46	\$202.23	\$485.35
	Employee + spouse	\$301.62	\$150.81	\$361.94
	Employee + family	\$533.20	\$266.60	\$639.84

Permanent part-time employees working 20-30 hours per week may participate in the health care plan at full cost.

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Out-of-Network - pertains to a non-participating provider. If you visit a non-participating provider, you are Out-of-Network. **Only Qualified Emergencies or Urgent Care will be covered.**

¹ See page 29 for explanation

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* Health Plan pays 70% of AC. You pay 30% of AC, and **you may be subject to balance billing by Out-of-Network providers for amounts in excess of AC.**

⁺⁺ In-Network Deductible does not apply.

Exclusions

The Following Services Are Not Covered Under the Benefit Plans

- **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, acupuncture; aroma therapy; behavior training; biofeedback; hair analysis; herbal, vitamin or dietary products or therapies; hippotherapy; holistic medicine; homeopathy; hypnotherapy; massage therapy; recreational therapy and sleep therapy.
- **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.)**
- **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 Plan Documents
- **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 Plan Documents; 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 Plan Documents; 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 Plan Documents
- **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 Plan Documents
- **Eye:** Routine eye exams; any services for eyeglasses or contact lenses including refraction; 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:** air conditioners; batteries and battery chargers; bedliners; breast pumps; canes; cervical collars; convenience items (telephone, television, etc.); corsets; cranial helmets; dehumidifiers; elastic/leather braces or supports; exercise equipment; expenses incurred at a health spa, gym or similar facility; filters; grab or tub bars; heating pads; home improvement items (escalators, elevators, etc.); humidifiers; mattress covers; office chairs; office visits for the purpose of fitting a noncovered device or supply; OTC medical supplies which do not require a prescription (Band-Aids, antibiotic cream, vita lights, magnetic mats); rental/purchase of TENS units; splints; sun/heat lamps; take home medications; traction apparatus; tub benches; whirlpool baths
- **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
- **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.
- **Pregnancy:** Implantation services for any reason
- **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 specifically listed as covered in the Plan Documents
- **Robotics:** Charges related to robotics during surgery
- **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 The County of Henrico Health Plan except as described in the Plan Document. Service and supplies for smoking cessation and nicotine addiction except as specifically offered by the plan. 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 and your 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**
- **Work hardening programs**

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 Plan Documents. This material is to be used for informational purposes only.

¹ **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. 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.

² **Out-of-Pocket Maximums:** All amounts paid by the Member for both In-Network and Out-of-Network care for Covered Services contribute toward the Annual Out-of-Pocket Maximum, except for the following: chiropractic care, prescription drugs, vision service expenses, charges incurred for noncovered expenses, notification penalties, charges in excess of day or dollar limits, and amounts in excess of Allowable Charge.

³ **In-Network Transplant Services** are accessed through the Coventry Transplant Network and require prior authorization. Call 1-866-533-5149.