SOUTHERN HEALTH SERVICES, INC.
A Coventry Health Care Plan

County of Albemarle Plus Plan
Schedule of Benefits

OUTPATIENT SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Preventative Services (as defined by the plan)	$0	30% AC[1]
Physician Home/Office Visit (includes allergy testing/treatment)		
Primary Care Visit	$15	30% AC [1]
Specialist Visit including OB-GYN physician	$30	30% AC [1]
Allergy Serum & Allergy Injections		
Primary Care Visit	$15	30% AC [1]
Specialist Visit	$30	30% AC [1]
In-Network, if the office visit Copayment is greater than the amount of the serum & injection, then the Member will only be charged the amount of the serum & injection.		
Lab Services	10% AC	30% AC [1]
Mammogram	$0	30% AC [1]
Diagnostic Services (other than specialty diagnostics)	10% AC	30% AC [1]
Colonoscopy	$0	30% AC [1]
Specialty Diagnostic Services Including, but not limited to, MRA, MRI, CAT Scan, PET Scan, and Sleep Studies	10% AC	30% AC [1]
Outpatient Facility/Outpatient Surgery		
To facility	10% AC	30% AC [1]
To physician or professional provider	$15 PCP/$30 Specialist	
Spinal Manipulations Maximum of 25 outpatient visits per Benefit Year	$15	30% AC [1]
Urgent Care Center When Medically Necessary, as determined by Southern Health	$35	

MATERNITY SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Prenatal Care & Postpartum Home or Office Visit (after the initial office visit for diagnosis of Pregnancy)	$0	30% AC [1]
Maternity Ultrasounds	10% AC	30% AC [1]
Inpatient Hospital Services		
Total per admission	10% AC	30% AC [1]
Inpatient PCP/OB-GYN services	$50	30% AC [1]

EMERGENCY CARE	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Emergency Room Services (Co-payment waived if admitted.) Total per admission	$200	
Ambulance Transportation Non-emergency transportation must be Preauthorized by Southern Health.	$0	$0

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Inpatient Total per admission to facility and each professional provider	10% AC	30% AC [1]
Outpatient	$15	30% AC [1]
Medication Management Visit (unlimited)	$15 PCP/$30 Specialist	30% AC [1]

INPATIENT HOSPITAL SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Total per admission	10% AC	30% AC [1]

[1] After the Deductible. [2] Does NOT apply to out-of-pocket maximum. AC – Allowable Charge

OTHER BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Cardiac Rehabilitation Therapy		
Maximum 18 outpatient visits per condition.	$0	30% AC [1]
Durable Medical Equipment (DME) [2]	20% AC	30% AC [1]
Early Intervention Services		
For qualified dependents from birth to age 3. See eligibility requirements in your *Description of Benefits.*		
Home or Outpatient Therapy and Assistive Technology Services	$15 PCP/$30 Specialist	30% AC [1]
Assistive Technology Devices	$0	30% AC [1]
Home Health Care Services		
Maximum 90 visit per Benefit Year	$0	30% AC [1]
Hospice Care	$0	30% AC [1]
Infusion Therapy (including Chemotherapy), Radiation Therapy & Dialysis	10% AC	30% AC [1]
Non-Implanted Prosthetic Devices [2]	20% AC	30% AC [1]
Occupational, Speech and Physical Therapy		
Inpatient - Maximum 180 days per Condition		
Total per admission	10% AC	30% AC [1]
Outpatient – Maximum 90 visits per Benefit Year		
Per visit	$30	30% AC [1]
Skilled Nursing Facility		
Maximum 180 inpatient days per Benefit Year	10% AC	30% AC [1]
Wisdom Tooth Extraction (bony impacted or soft tissue)		
Performed in provider's office	$15 PCP/$30 Specialist	30% AC [1]
Performed in outpatient facility	$15 PCP/$30 Specialist	30% AC [1]

VISION [2] (One eye exam during a 12 month period)	In-Network	Out-of-Network
Spectacle Eye Exam	$0	30% AC [1]
Eye Exam for non-specialty contact lenses	$35	30% AC [1]
Eye Exam for specialty contact lenses	Benefit payable $40	30% AC [1]

PRESCRIPTION DRUG BENEFIT [2]	Member Pays
For up to a 31 day supply	
Generic*	$7
Preferred Brand*	$30
Non-Preferred Brand*	$50
For up to a 90 day supply through mail-order program	
Generic (for up to a 90 day supply)	$14
Preferred Brand	$60
Non-Preferred Brand	$100

DEDUCTIBLES AND MAXIMUMS	In-Network	Out-of-Network
Benefit Year Out-of-Pocket Maximum		
Individual	$2,000	$3,000
Family	$4,000	$6,000
Lifetime Maximum Benefit Per Member	Unlimited	
Benefit Year Deductible		
Individual	$0	$750
Family	$0	$1,500

Southern Health's Benefit Payable is calculated after subtracting from the AC any applicable Deductible, Copayment, Coinsurance or Penalty owed by the Member. All Benefit Maximums are combined for In-Network and Out-of-Network unless otherwise specified.

NOTIFICATION PENALTY: Failure to comply with the Notification procedures outlined in the *Description of Benefits* may result in a $500 penalty. This penalty, when required, will be subtracted from the AC before calculating any Coinsurance that may apply. It is also subtracted before any amount You pay applies to a Deductible or Copayment.

BENEFITS AND BENEFIT YEAR: Benefits listed in this Schedule of Benefits are for Covered Services only. The Benefit Year is the plan year.

[1] After the Deductible [2] Does NOT apply to out-of-pocket maximum. * For Retail Maintenance Drugs, the Member pays 3 Co-payments for 3 Prescribing Units. AC – Allowable Charge