POS
Evidence of Coverage
Southern Health Services, Inc.

SH.POS.11-09
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Definitions

Affiliated Companies
Southern Health’s parent company is Coventry Health Care, Inc. (Coventry). Coventry is the parent company of several managed care companies, health maintenance organizations, insurance companies, third party administrators, and network rental companies. Coventry and its subsidiaries are considered Affiliated Companies of Southern Health. These Affiliated Companies include, but are not limited to, Carelink Health Plans, Inc., WellPath Select, Inc., Coventry Health and Life Insurance Company, and First Health Group Corp.

Allowable Charge
The Allowable Charge is the amount that a Participating Provider has agreed to accept as payment in full for Covered Services. For Non-Participating Providers the Allowable Charge is equal to the Out-of-Network Rate.

Benefit Maximum
The Benefit Maximum is the total amount payable for a service. Limits may be in terms of visits, days, or dollars. Specific Benefit Maximum amounts are listed in the Schedule of Benefits.

Benefit Year
The Benefit Year is the period during which the total amount of yearly benefits under Your coverage is calculated. This period is either a calendar year or a contract year, as specified in the Schedule of Benefits for Your group.

Biologically-Based Mental Illness
Any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person’s functioning. Specifically, the following diagnoses are considered Biologically-Based Mental Illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Coinsurance
A specified percentage of the Allowable Charge that You must pay as a condition of the receipt of certain services as provided in this Evidence of Coverage. Specific Coinsurance amounts are listed in the Schedule of Benefits. In some circumstances, the Allowable Charge will be more than the charges the provider has billed for the Covered Services. In these cases, You will still be responsible for Coinsurance based on the Allowable Charge.

Copayment
A specified dollar amount You must pay as a condition of the receipt of certain services as provided in this Evidence of Coverage. Specific Copayment amounts are listed in the Schedule of Benefits.

Cosmetic Services and Surgery
Services and/or plastic reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) is done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

Coventry Health Care
A recorded trade name for Southern Health Services, Inc.
Covered Services
The services or supplies provided to You for which Southern Health will make payment, as described in Section 6 of this Evidence of Coverage.

Custodial Care
Custodial Care is maintenance care or on-going medical care that is not designed to improve the patient’s condition when the patient’s medical condition has stabilized, regardless of the place of service or the provider by whom the services are prescribed, recommended or performed. Custodial Care may include, but is not limited to, the following services: activities of daily living such as, help walking, getting into or out of bed, bathing, dressing, feeding, and using or applying medications; routine palliative and prophylactic skin care; administration and supervision of catheters, colostomies, tracheotomy, intravenous feeding or ventilator care.

Customer Service Department
Southern Health’s Customer Service Department, which includes member services. The number for the Customer Service Department is located on Your Member ID card.

Deductible
A fixed dollar amount of Covered Services that a Member is responsible for paying in a Benefit Year before Southern Health will pay for any remaining Covered Services during the Benefit Year. Amounts above the Allowable Charge do not accumulate towards the Deductible.

Dependent
Any member of a Subscriber’s family or any other class of covered individuals who meet the eligibility requirements outlined in this Evidence of Coverage and the Group Agreement/Policy.

Directory of Health Care Providers
A listing of Participating Providers that is compiled and maintained by Southern Health. The information in the Directory of Health Care Providers is subject to change. Upon request, an updated Directory of Health Care Providers will be sent to You at least once each Benefit Year. You can also locate Participating Providers through the provider search on the Southern Health website.

Enrollment/Change Form
Southern Health’s form that You complete before Your effective date. This form allows You to have coverage through Southern Health.

Experimental/Investigational
Except as covered in Section 6 under Clinical Trials,” medical, surgical or other health care procedures, services or supplies are considered Experimental or Investigational if any of the following applies:
♦ Is in the testing stage or in early field trials on animals or humans.
♦ Is under clinical investigation by health professionals or are undergoing clinical trials by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration (FDA). Any drug not approved for use by the FDA, any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature, or any drug that is classified as an Investigational New Drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA. Drugs for the treatment of a specific type of cancer that are not FDA approved will be covered when they are approved for one type of cancer for which the drug has been prescribed in any of the standard reference compendia. Similarly drugs for the treatment of a specific indication that are not FDA approved will be covered so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature.
♦ Is a health product or service that is subject to Institutional Review Board (IRB) review or approval.
Definitions

Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered in the “Clinical Trials” paragraph under the Section Covered Benefits.

Does not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare.

Is a health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

Group Agreement/Policy
The contractual agreement Southern Health enters into with the Subscriber’s employer for health care coverage. This agreement consists of the group contract, the group application and any attachments and/or amendments to the application or contract.

In-Network
Pertaining to the payment level for services received from a Southern Health Participating Provider.

Institutional Review Board (IRB)
IRB is a generic term used by the Food and Drug Administration (FDA) and Health and Human Services (HHS) to refer to a group or committee who reviews and monitors biomedical research involving humans to assure the protection of the rights and welfare of research subjects. An IRB has the authority to approve, require modifications in (to secure approval), or disapprove research.

Medical Emergency/Emergency
A Medical Emergency is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson to result in (i) serious jeopardy to the mental or physical health of the Member, (ii) danger of serious impairment of the Member’s bodily functions, (iii) serious dysfunction of any of the Member’s bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Medically Necessary/Medical Necessity
Those services, supplies, equipment, and facilities charges that are not expressly excluded under this Evidence of Coverage and have been determined by Southern Health to be: (i) medically appropriate, which means that the expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin; (ii) necessary to meet the basic health needs of the Member as a minimum requirement; (iii) rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service; (iv) consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations, or governmental agencies that are accepted by the plan; (v) consistent with the diagnosis of the condition; (vi) required for reasons other than the comfort or convenience of the Member or his or her physician; and (vii) of demonstrated value based on clinical evidence reported by peer reviewed medical literature and by generally recognized academic medical experts; this is, it is not Experimental or Investigational or unproven.

Member
Any Subscriber or Dependent covered under a Southern Health policy.

Non-Participating Provider
A health care provider or facility that has not directly or indirectly executed an agreement with Southern Health to participate in its network.
Out-of-Network
Pertaining to the payment level for services received from a Non-Participating Provider.

Out-of-Network Rate
Out-of-Network Rate means the amount Southern Health pays for Covered Services furnished by Non-Participating Providers. The Out-of-Network rate is based on a defined Virginia Medicare fee schedule, a fixed per diem rate, a Virginia St. Anthony's fee schedule, or a fixed percentage of billed charges. The type and place of service determines the applicable schedule/rate. Southern Health's Allowable Charge policy provides further details on the determination/calculation of Out-of-Network Rates. Members may contact Customer Service to request a copy of the current Allowable Charge policy or to inquire about specific services and the applicable Out-of-Network rates.

Participating Primary Care Physician (PCP)
A Physician who is selected from the Southern Health Provider Network and is classified as a Primary Care Physician in the Directory of Health Care Providers. This Physician is available to assist in managing a Member’s care.

Participating Provider/Provider Network
A physician, hospital, Skilled Nursing Facility, pharmacy, or other duly licensed institution, health professional, or organization of duly licensed health care institutions and/or health professionals that has directly or indirectly executed an agreement with Southern Health to participate in its network. The Directory of Health Care Providers lists Participating Providers/Provider Network; however, be aware that the information in the Directory is subject to change. You can also search for Participating Providers on the Southern Health website.

Passport Program
A program that allows Dependents residing permanently or temporarily outside Southern Health’s designated Service Area to access Affiliated Companies’ provider networks at the In-Network level of benefits for certain Covered Services.

Peer-Reviewed Medical Literature
A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

Preauthorization
Approval by Southern Health that is required for payment for certain services to be performed. Preauthorization does not guarantee payment if the Member is not covered at the time the service is provided. Preauthorization does not guarantee payment at the In-Network benefit level for services rendered by Non-Participating Providers.

Preventive Care Guidelines
Preventive Care Guidelines are established by Southern Health and updated at least annually. They are made available to Participating Providers and Members upon request and are also available on the Southern Health website.

Preventive Care Services
Preventive Care Services are Covered Services provided to prevent or arrest the further manifestation of human illness or injury. These services include, but may not be limited to periodic health evaluations, including tests and diagnostic procedures in connection with routine examinations, such as adult physical examinations and well woman examinations; well-child examinations; preventive adult and child
Definitions

immunizations; and mammography. Preventive Care services do not include any service or benefit intended to treat an existing illness, injury or condition.

Prosthetic Limb
An artificial device to replace, in whole or in part, an arm, hand, leg, foot or any portion of an arm, hand, leg or foot.

Prudent Layperson
A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent Layperson will be considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

Retiree
Shall mean a former employee of an employer group who meets the group’s definition of retired employees to whom the group offers coverage under this Evidence of Coverage.

Schedule of Benefits
A schedule of covered benefits, fully discussed in this Evidence of Coverage and the Group Agreement/Policy, which delineates the Member’s Copayments, Coinsurance, Deductibles, out-of-pocket maximums, and other benefit limitations. The Schedule of Benefits is included with this Evidence of Coverage.

Service Area
The geographic area served by Southern Health as approved by the Virginia State Corporation Commission and/or the Virginia Department of Health as shown on the Service Area map in this Evidence of Coverage. Southern Health’s licensed Service Area is subject to change.

Short-Term Rehabilitative Therapy
Physical, speech and occupational therapy provided on an inpatient or an outpatient basis if significant improvement can be expected within 90 consecutive days.

Skilled Nursing Facility
An institution or a distinct part of an institution that primarily provides inpatient skilled nursing care and related services or rehabilitation services to injured, disabled or sick persons.

Southern Health
Southern Health Services, Inc.

Specialty Care Physician/Specialist
A physician who provides medical services to Members within the range of a medical specialty.

Standard Reference Compendia (DrugPoints)
The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia Dispensing Information.

Subscriber
The eligible employee (or retiree, if applicable) who has elected Southern Health coverage.

Total Disability/Totally Disabled
Complete inability of the Member to perform all of the substantial and material duties of his or her regular occupation for a period of duration of at least 180 days or complete inability of the Member to engage in an employment or occupation for at least 180 days for which he or she is or becomes qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means complete
inability for at least 180 days of the Member to engage in most of the normal activities of a person of like age and gender. The disability for Subscriber or Dependent must require regular care and attendance by a physician who is someone other than an immediate family member.

**Urgent Care**
Urgent Care is Medically Necessary care for an unexpected illness or injury that You need sooner than a routine doctor’s visit.

**You/Your**
A Member covered under this *Evidence of Coverage*. 
Important Information About Your Coverage

In the event You need to contact someone about Your contract for coverage for any reason, please contact Your agent. If no agent was involved in the sale of this contract, or if You have additional questions, You may contact Southern Health at:

Southern Health Services, Inc.
Customer Service Department
P.O. Box 7704
London, Kentucky 40742
(800) 627-4872
FAX: (302) 283-6785
WEB PAGE: www.southernhealth.com

We recommend that You familiarize Yourself with our complaint and appeal procedure, and make use of it before taking any other action. The addresses and telephone numbers for complaints and written appeals are listed below:

Complaints:
Southern Health Services, Inc.
Attention: Customer Service Department
P. O. Box 7704
London, Kentucky 40742
(800) 627-4872
FAX: (302) 283-6785

Appeals:
Southern Health Services, Inc.
Attention: Appeals Coordinator
9881 Mayland Drive
Richmond, VA 23233
(800) 627-4872
FAX: (804) 747-8836

If You have been unable to contact or obtain satisfaction from Southern Health or the agent, You may contact the Virginia State Corporation Commission’s Bureau of Insurance at:

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
(804) 371-9741, local
(800) 552-7945, in-state toll-free number
(877) 310-6560, national toll-free number

Complaints regarding Your coverage may also be directed to the Office of Licensure and Certification of the Virginia Department of Health at (800) 955-1819.

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, Southern Health the Bureau of Insurance or the Department of Health, have Your Member ID card available.

This Evidence of Coverage and Southern Health’s Customer Service Department are Your best resources for information about Your health plan. It is Your responsibility to know and understand Your benefits.
Section 1: Important Information About Your Coverage

This Evidence of Coverage is not a complete description of Your Southern Health policy. This document summarizes certain applicable provisions from the Group Agreement between Your employer and Southern Health. By enrolling in Southern Health, You have agreed to abide by the applicable terms and conditions of both the Group Agreement and this Evidence of Coverage.

Together, this Evidence of Coverage, its attachments and any amendments and/or riders, the Schedule of Benefits, Enrollment/Change Form, and the Group Agreement and its amendments constitute the entire contractual agreement between You and Southern Health. No portion of the charter, by-laws, or other Southern Health document shall constitute part of this contract except as set forth in the entire contractual agreement. No oral statement of any person, including employees of Southern Health, shall modify or otherwise affect the benefits, limitations, and exclusions of this Evidence of Coverage, convey or void any coverage, increase or reduce any benefits under this Evidence of Coverage, or be used in the support or defense of a claim under this coverage. The effective date of coverage for each Member’s current benefits is indicated on Your Member ID card.

Point-of-Service (POS)

In order to fully understand Your benefits, it is important for You to read and understand this Evidence of Coverage. This POS plan allows You to choose whether to receive benefits from providers who participate in the Southern Health network or to go outside of that network to receive care at a reduced level of coverage. This Evidence of Coverage describes the benefits for which You and Your covered Dependents are eligible.

Discounts and Rebates

In the event that a Pharmacy Rider has been purchased, You understand and agree that Coventry Prescription Management Services, Inc. may receive a retrospective discount or rebate from a vendor or manufacturer related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Southern Health Services, Inc. and its affiliates. You will not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, when determining prospective premium calculations for health care plans offered and/or administered by Southern Health Services, Inc.

Value Added Services

From time to time Southern Health may offer to provide You access to discounts on health care related goods or services. While Southern Health has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to You for the provision of such goods and/or services. Southern Health is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, Southern Health is not liable for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

Facts about Southern Health

Southern Health Services, Inc. (Southern Health) is a medical plan known as a health maintenance organization (HMO), and is subject to regulation in Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 of the Code of Virginia and the Virginia Department of Health pursuant to Title 32.1 of the Code of Virginia. Southern Health contracts with physicians, hospitals, pharmacies, and other medical providers to deliver Covered Services to its Members. Southern Health’s provider network is comprised of these Participating Providers. The In-Network level of benefits, in most cases, is available only from Southern Health Participating Providers except in the event of a Medical Emergency. Benefits provided by
non-participating pharmacies (if Your group has elected the prescription drug rider) that have previously notified Southern Health, by facsimile or otherwise, of their agreement to accept as payment in full reimbursement for their services at rates available to pharmacies that are Participating Providers, including any Copayment, Coinsurance, and/or Deductible consistently imposed by Southern Health, are also eligible for the In-Network level of benefits. Southern Health makes payment directly to Participating Providers for services received. Participating Providers are independent contractors and should not be considered agents or representatives of Southern Health. It is the Member’s responsibility to ensure that all claims are filed for Out-of-Network services received.
Member Rights and Responsibilities

Members’ Rights
Southern Health is committed to treating Members in a manner that respects their rights as Members. In addition, the services described in this Evidence of Coverage will be accessible to all covered persons, including those with diverse cultural and ethnic backgrounds and those with physical and mental disabilities.

Members of Southern Health have the right to:

- Be provided with accurate information about Southern Health’s services, benefits, their rights and responsibilities, and Participating Providers.
- Participate with their physician in decisions made regarding their health care.
- Have access to the Southern Health Customer Service Department.
- Discuss appropriate or Medically Necessary treatment options for medical conditions, regardless of the cost or benefit coverage.
- Be treated with respect and recognition of their dignity and need for privacy and confidentiality.
- Voice complaints and appeals about this organization or the care provided by Participating Providers and to have a clear, documented method for addressing any complaints and appeals.
- Request a description of all types of payment arrangements that Southern Health uses to compensate providers for health care services rendered to Members. These payment arrangements may include, but are not limited to, withholds, bonus payments, capitation, and fee-for-service discounts.
- To make recommendations regarding Southern Health’s Member Rights and Responsibility policy.
- To discuss utilization management questions with Utilization Management staff by phone, Monday through Friday between 8:30 am and 5:00 pm by calling the Customer Service number on Your Member ID card, or by fax 24 hours a day, 7 days a week at 804-968-4304 or 804-935-0265 or toll-free fax at 800-586-7015 or 866-715-4720.

Members’ Responsibilities to Providers
Southern Health Members have the responsibility for cooperating with providers of health care services by:

- Providing information needed by health care professionals.
- Informing the provider’s office and facility staff of their coverage with Southern Health and notifying office and facility staff if their coverage ends.
- Following instructions and guidelines given by health care providers. Failure to comply with recommended treatment is an option for Members. However, when a Member fails to comply with the recommended treatment, Southern Health will have no further liability to pay for treatment for the particular condition until such time that the Member later decides to follow the prescribed treatment, assuming the prescribed treatment is a Covered Service.
Southern Health will not be responsible for payment of services that may otherwise be Covered Services but that in Southern Health’s discretion are the direct result of the Member’s initial refusal to follow the recommended treatment.

- Cooperating with practitioners and providers of health care services by understanding their health problems and participating in the development of a mutually agreed upon treatment goal to the degree possible.

**Members’ Responsibilities to Know How and When to Seek Care**

Southern Health Members have the responsibility of knowing their health benefits, as well as any procedures required for seeking care, such as:

- Knowing whether they are seeking care from a Participating or Non-Participating Provider. In most cases, benefits will vary according to the participation status of the provider delivering Covered Services.
- Verifying the current participation status of any provider for their specific benefit plan prior to receiving services.
- Always obtaining any required Preauthorization as described in Section 3 of this Evidence of Coverage. If they need to seek services from a Non-Participating Provider, they will need to ensure that Southern Health has approved the services before receiving Covered Services.
- Understanding the terms and limitations of Preauthorizations for Covered Services and whether Preauthorizations are approved at the In-Network or Out-of-Network benefit level.
- Obtaining Preauthorization from Southern Health prior to continuation of care if they or a covered family member is receiving health care from a Non-Participating Provider when they enroll. This applies only if they want the services to be eligible for payment at the In-Network benefit level. They should consult with their PCPs or treating physicians who will call Southern Health to obtain Preauthorizations.
- **Knowing the Preauthorization requirements that apply to both In- and Out-of-Network benefits and understanding the terms of their Preauthorization.**
- Understanding the role of their Primary Care Physician in the coordination of their overall health care.
- Accessing behavioral health and substance abuse services as described in Section 6 of this Evidence of Coverage.
- Southern Health Members have the responsibility of promptly notifying Southern Health of any address or telephone number changes. If correspondence is not received because a Subscriber has failed to notify Southern Health of an address change, the Member or their Dependent’s coverage could be terminated or not renewed in accordance with the terms and conditions of this contract without their knowledge. They will be responsible for expenses incurred as a direct result of their not notifying Southern Health of any address or telephone number change.
- Checking with their employers regarding Dependent eligibility and notifying Southern Health within thirty-one (31) days of any changes.
- Making sure all family members are aware of the correct procedures for obtaining benefits through Southern Health.

**Failure to meet the responsibilities listed in this Section may cause You to be financially responsible for services provided.**
Using Your Benefits

Primary Care Physician
Southern Health Participating Providers are solely responsible for the treatment and medical care of Southern Health Members who are their patients. Southern Health decisions are only determinations as to whether a service that a Member has or will receive is a Covered Service. Therefore, Southern Health is not liable for the treatment decisions made by treating physicians.

Southern Health Members choose their Primary Care Physician (PCP) from the Directory of Health Care Providers, a listing which includes Participating Family and General Practitioners, Internists, and Pediatricians. Your PCP will assist You in coordinating Your medical care. You may contact Southern Health or the individual provider offices for qualifications, specifics of a physician’s training and experience, office hours and policies, and other areas that may be of interest to You. A different PCP may be selected for each member of the family.

In order to receive benefits at the In-Network benefit level, all non-emergency care must be received from Participating Providers. Covered Services rendered by Non-Participating Providers are covered at the In-Network level of benefits only when Southern Health determines a Participating Provider cannot meet Your health care needs and the services are Preauthorized for payment at the In-Network benefit level. Members may visit a Non-Participating Provider without Southern Health’s approval; however, such services will be eligible only for the Out-of-Network benefit level. Additionally, if the service requires Southern Health’s Preauthorization and it is not obtained prior to receipt of the service, coverage for the service will be denied.

If during Your coverage Your PCP ceases to participate with Southern Health, You will be notified by Southern Health and You will have the opportunity to select another Participating PCP. You may call Customer Service for assistance with selecting another Participating PCP whose practice is open to Southern Health Members in the type of product in which You are enrolled.

Obstetrician/Gynecologist Physician
Female Members age 13 or older may choose a Participating Obstetrician/Gynecologist (OB-GYN) physician in addition to their PCP and seek health care services directly from their OB-GYN physician. Selection can be made from the list of OB-GYN physicians in the Directory of Health Care Providers. If during Your coverage Your OB-GYN ceases to participate with Southern Health, You will be notified by Southern Health and You will have the opportunity to select a new OB-GYN. If Your OB-GYN physician feels that You need to receive care from a Non-Participating Provider, then the OB-GYN physician can call Southern Health to initiate the Preauthorization process for You. Any non-emergent visits to Non-Participating Providers without Preauthorization from Southern Health will be eligible only for Out-of-Network benefits. Covered Services received from Non-Participating Providers are only eligible for the In-Network benefit level when a Participating Provider cannot provide the needed service and after Southern Health has issued Preauthorization.
Changing Your PCP or OB-GYN Physician

If you want to change your PCP or OB-GYN physician, call Southern Health’s Customer Service Department before you visit your new PCP or OB-GYN to verify that the physician is a Participating Provider with Southern Health.

Continuing Services from Providers

If your Participating Provider leaves the Southern Health Network, you may continue to receive Covered Services from this provider in the following cases:

You may receive Covered Services from your PCP for a period of 90 days after the date a Participating Provider has given to, or received from, Southern Health notice that his or her participation status is terminating, as long as the provider remains in the Service Area and is open to see patients.

You may receive Covered Services from providers other than your PCP for a period of 90 days from the date of the notice of a provider’s termination from Southern Health’s network, if you were in an active course of treatment with a Participating Provider prior to the provider’s notice of termination from Southern Health’s network, and you request to continue receiving health care services from the provider.

You are able to receive care for extended periods under the following circumstances:

♦ If you have entered your second trimester of pregnancy at the time a provider’s participation is terminated you may continue receiving services directly related to the delivery from that provider through post-partum care.

♦ If you have been determined to have a medical prognosis of life expectancy that is six months or less you may continue to receive treatment from such provider for the remainder of the Your life for care directly related to the treatment of the terminal illness.

The continuity of care options described above are not available if your Provider is terminated for cause or if you cease to be a Southern Health Member. Southern Health will reimburse the provider for Covered Services you receive pursuant to this section in accordance with Southern Health’s agreement with the provider that is in effect immediately preceding the termination of the provider from the Southern Health Network.

Non-participating Pharmacies

If your group has elected a prescription drug rider, you are entitled to receive your prescriptions at a Participating pharmacy. A list of participating pharmacies may be found in the Directory of Health Care Providers. If your group has elected the prescription drug rider, you are also entitled to receive care from a non-participating pharmacy that has previously notified Southern Health, by facsimile or otherwise, of its agreement to accept as payment in full reimbursement for its services at rates available to a pharmacy that is a Participating Provider, including any Copayment, Coinsurance, and/or Deductible consistently imposed by Southern Health. Southern Health will not be responsible for payment to non-participating pharmacies that have not previously notified Southern Health, by facsimile or otherwise, of their agreement to accept as payment in full reimbursement for their services at rates available to pharmacies that are Participating Providers, including any Copayment, Coinsurance, and/or Deductible consistently imposed by Southern Health, nor will Southern Health be responsible for reimbursing Members who have prescriptions filled at such pharmacies.

You will still need to obtain Preauthorization for those medications and supplies requiring Preauthorization.
Section 3: Using Your Benefits

Any description in this Evidence of Coverage of Covered Services provided by a non-participating pharmacy will be based on the assumption that such pharmacy has previously notified Southern Health, by facsimile or otherwise, of its agreement to accept as payment in full reimbursement for its services at rates available to a pharmacy that is a Participating Provider, including any Copayment, Coinsurance, and/or Deductible consistently imposed by Southern Health.

Access to Participating Providers

Your PCP is an important resource in maintaining good health. Southern Health strongly recommends that You work closely with Your PCP in coordinating Your preventive and health care needs. You are encouraged to consult with Your PCP when medical care is needed. By consulting Your PCP, You will be able to access covered wellness benefits, receive advice regarding the need for Specialist care, obtain medical guidance in selecting a participating Specialist for Your needs, and receive overall coordination of Your health care.

Referrals from Your PCP for office visits to other Participating Providers are not required in order to receive In-Network benefits. Members may access any Specialist directly to receive Covered Services. If a Member visits any Non-Participating Provider, Covered Services will be eligible for coverage at the Out-of-Network benefit level. If a Member visits any Participating Provider, Covered Services will be eligible for coverage at the In-Network benefit level. Preauthorization procedures still apply as outlined in this Section. Services received in a Medical Emergency may be eligible for coverage at the In-Network benefit level as stated in Section 6. Participating and Non-Participating PCPs as well as Specialists are able to request Preauthorization for procedures, tests, and other medical services that are Covered Services and Medically Necessary. Any questions as to whether a service is considered a Covered Service as well as what services require Preauthorization may be directed to Southern Health Customer Service at the number on Your Member ID card.

When a visit to a health care provider is Medically Necessary, it is critical that You first refer to the Directory of Health Care Providers, visit the Southern Health website or contact Southern Health to determine if the provider participates in Your particular Southern Health plan in order to receive services at the In-Network benefit level. When calling, please remind the Customer Service representative of the type of product (e.g. HMO, Employer Specific) in which You are enrolled as indicated on Your Member ID card. The Directory of Health Care Providers and the provider information on the Southern Health website are updated periodically; however, a provider’s participation status can change at any time. There is no guarantee that a provider listed in the Directory of Health Care Providers or on the website still participates with Southern Health. Only services rendered by providers participating with Southern Health at the time the services are rendered are Covered Services at the In-Network benefit level unless a Primary Care or OB-GYN Physician has requested and received a Preauthorization from Southern Health prior to sending You to a Non-Participating Provider.

Outpatient Laboratory Services (In-Network Only)

Outpatient laboratory services must be performed at either Your physician’s office or at one of the locations of the Participating laboratories listed in the Directory of Health Care Providers. In some cases, testing must be performed at a Southern Health designated facility. Participating Providers are informed of Participating laboratories and designated testing facilities.

Services Requiring Preauthorization

Certain medical or surgical procedures, diagnostic tests, supplies, or medications require Preauthorization from Southern Health to be considered Covered Services. The appropriate Preauthorizations must be obtained regardless of whether You are using Your In- or Out-
of-Network level of benefits. Preauthorization is required even when this Southern Health plan is the secondary carrier; otherwise, Your claim will be denied.

A list of services requiring Preauthorization is provided available on the Southern Health website. You may also request a copy of the list by calling the Southern Health Customer Service Department This list may be periodically updated by Southern Health

Preauthorization is required prior to the date of service. In order to allow sufficient time for the Preauthorization process, Your physician must contact Us for Preauthorization at least three working days prior to Your scheduled receipt of the service or procedure.

Preauthorization for behavioral health and substance abuse services must be requested from the contracted behavioral health vendor. The phone number for the behavioral health vendor is listed in the Directory of Health Care Providers and on Your Member ID card.

If You are seeing a Participating Provider, the Provider ordering the service must contact Southern Health to get Preauthorization. Please have Your physician contact Southern Health by calling (800) 235-2206. Medical information may also be faxed to the Preauthorization Department at (800) 968-4304. Should Your physician need to mail information that can not be faxed such as x-rays, dental impressions or pictures, those may be included with a letter of Medical Necessity and sent to:

Southern Health Services, Inc.
Attention: Preauthorization Department
9881 Mayland Drive
Richmond, VA 23233

Southern Health reserves the right to require documentation of Medical Necessity and/or second opinions prior to Preauthorization of Covered Services. Notwithstanding any review conducted by Southern Health, before the provision of a health care service, all benefits are subject to the terms and conditions of this Evidence of Coverage.

If You are unable to receive the service on the assigned date, You must notify Your physician who will contact Southern Health to update the Preauthorization. Southern Health will provide notification of the new date of the Preauthorization to Your physician.

If You participate in the Passport Program and receive services from an Affiliated Company’s provider, You are responsible for making sure the provider obtains any necessary Preauthorizations. You may be required to return to the Services Area in order for certain complex services requiring Preauthorization to be covered at the In-Network benefit level.

If You receive services from a Non-Participating Provider, You are responsible for making sure Your provider obtains any necessary Preauthorizations. Section 10 further describes the guidelines and your responsibilities when services are received from a Non-Participating Provider.

If You or Your provider fail to follow the procedures listed above for obtaining Preauthorization, Your claim will be denied. In this situation, You may be responsible for all amounts charged by the provider.

All Payments for Preauthorized services will be subject to the applicable limitations, exclusions, and conditions of Your coverage.
Obtaining Preauthorization for Visits to Non-Participating Providers at the In-Network Benefit Level

If Your physician feels that You need to see a physician or other medical provider who does not participate with Southern Health and You believe these services may be eligible for In-Network benefits, then Your physician must submit, in writing, medical information to Southern Health prior to You receiving services. Retroactive requests for consideration at the In-Network benefit level will not be considered. Covered Services from Non-Participating Providers are Preauthorized by Southern Health for In-Network benefits only when Southern Health does not have a Participating Provider who can provide the service. Your physician must submit evidence that participating Southern Health providers are unable to perform the requested services. Southern Health has the right to determine where the service can be provided for coverage when a Participating Provider cannot render the service.

Your responsibilities when seeking services from Non-Participating Providers at the In-Network level:

♦ Administrative requirements usually fulfilled by Participating Providers are Your responsibility when seeing a Non-Participating Provider. This includes, but is not limited to, filing of claims within the timely filing period and obtaining Preauthorization prior to receiving services.

♦ Preauthorization for visits to Non-Participating Providers will be granted for a specified condition and are assigned a specific number of visits. If the services received vary from the services that were Preauthorized, those services will not be covered by Southern Health. Only those visits made after Preauthorization is given are covered. If You are unsure whether or not Your physician’s office has obtained a Preauthorization, or if You want to verify the number of visits or the expiration date, call Customer Service for assistance.

♦ If You are unable to schedule an appointment with the Non-Participating Provider on the date Preauthorized by Southern Health, Your physician must contact Southern Health to have the date of the Preauthorization changed to coordinate with Your new appointment date.

♦ If a Non-Participating Provider is still treating You and Your number of visits expires, Your physician must call Southern Health to have the number of visits increased or extended prior to receiving additional services.

Section 10 describes the guidelines for Your Out-of-Network coverage and responsibilities.
What You Pay

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<td>Member Responsibility:</td>
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<td>Coinsurance or Copayment</td>
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<td>Amounts above the Allowable Charge*</td>
<td>Allowable Charge minus Member responsibility</td>
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<td>Health Plan Responsibility:</td>
<td>Allowable Charge minus Member responsibility</td>
<td>Allowable Charge minus Member responsibility</td>
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<tr>
<td>Provider Responsibility:</td>
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* For a complete definition of Allowable Charge, please refer to the Definitions Section at the front of this Evidence of Coverage.

When Covered Services are received Out-of-Network Members will be responsible for any amounts over the Allowable Charge in addition to Copayments, Coinsurance, and/or Deductibles. The amount over the Allowable Charge will not be applied towards the Member’s Deductible or out-of-pocket maximum.

For example:
Non Participating Provider’s billed charges $50,000.00
Southern Health Allowable Charge is $20,000.00
Patient Responsibility $30,000.00* plus any Copayment, Coinsurance, and/or Deductible amounts according to Your medical benefit plan

*$30,000.00 is not applied towards Your Deductible or out-of-pocket maximum.

**Deductible**

The Deductible is the dollar amount of Covered Services that You must pay during the Benefit Year before Southern Health will pay for any Covered Services that are subject to the Deductible. Consult the Schedule of Benefits to determine the Deductible amount appropriate to Your plan and the services, which are subject to the Deductible. Amounts above the Allowable Charge do not accumulate towards the Deductible.

**Copayment/Coinsurance Amounts**

For benefits with Copayment responsibilities, You will pay a specific Copayment amount and the remainder will be covered in full up to the Allowable Charge.

For benefits with Coinsurance responsibilities, You will pay a percentage of the Allowable Charge and the remainder will be covered in full up to the Allowable Charge.

For plans with a Deductible, the Copayment or Coinsurance applies after the applicable Deductible has been satisfied if the service is subject to the Deductible.
In some circumstances, the Allowable Charge will be more than the charges the Provider has billed for the Covered Services. In these cases, You will still be responsible for Coinsurance based on the Allowable Charge. Additionally, when seeing a Non-Participating Provider, You are responsible for billed charges in excess of the Allowable Charge.

Consult the Schedule of Benefits to determine the Copayment and/or Coinsurance amounts appropriate to Your plan and the services that are subject to a Copayment or Coinsurance.

**Benefit Year Maximum Out-of-Pocket**

The maximum out-of-pocket is the highest amount of Copayments, Coinsurance, and Deductible amounts that any single Subscriber or family unit must pay in each Benefit Year. To determine how Your Benefit Year is calculated, consult the Schedule of Benefits. After You reach the stated out-of-pocket maximum, You will be notified by Southern Health and You will not be required to pay Copayments, Coinsurance, or Deductible amounts that have previously accumulated toward this maximum. The notification shall be given no later than 30 days after Southern Health has processed sufficient claims to determine that the maximum out-of-pocket has been reached. If You have paid amounts in excess of Your maximum out-of-pocket, those amounts will be promptly refunded to You. Consult the Schedule of Benefits to determine the maximum out-of-pocket amount appropriate to Your plan and the services that apply to the maximum out-of-pocket. Amounts above the Allowable Charge do not apply toward the maximum out-of-pocket.
Complaints and Appeals

Southern Health maintains both complaint and appeal procedures to resolve Member inquiries, complaints, and appeals. All claims of any nature against Southern Health, its employees, agents, board members, or officers, whether filed by a Member or the Authorized Representative, must first proceed through the complaint and appeal procedures. It is expressly understood that no action or proceeding may be pursued in court until the administrative remedies as provided in the complaint and appeal procedures are exhausted.

Providers may also file complaints and appeals on their own behalf. They have a separate appeals process, which is outlined in their Southern Health Provider Manual.

No Member who exercises the right to file a complaint or appeal shall be subject to termination or otherwise penalized due to the filing of a complaint or appeal.

Definitions Relating to the Complaint and Appeal Procedure

For the purposes of this Section, the following definitions apply:

**Administrative Adverse Benefit Determination**: Any Adverse Benefit Determination that is not an Adverse Decision.

**Adverse Benefit Determination**: A denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit. An Adverse Benefit Determination based in whole or in part on medical judgment, including the failure to cover services because they are determined to be Experimental/Investigational or not Medically Necessary, is also considered an Adverse Decision.

**Adverse Decision**: An Adverse Decision is a type of Adverse Benefit Determination involving a utilization review determination by Southern Health that the health care service rendered or proposed to be rendered is not Medically Necessary or is Experimental/Investigational, when such determination may result in noncoverage of the health care service. An Adverse Decision also includes a utilization review determination that (a) declines to grant an expedited review in a situation involving an alleged emergency medical condition; (b) declines to provide coverage or services for an alleged emergency medical condition, whether before or after granting an expedited review; or (c) denies benefits or coverage, and concerning which all internal Appeals available to the Member pursuant to Title 32.1 of the Code of Virginia have been exhausted.

**Appeal**: An Appeal is a request by the Member or the Member’s Authorized Representative for consideration of an Adverse Benefit Determination of a health service request or benefit that the Member believes he or she is entitled to receive. The Appeal must be received by Southern Health within 180 calendar days after the Member’s receipt of the Adverse Benefit Determination for it to be considered an Appeal. The Appeals procedures give Members the opportunity to ask Southern Health to review any matter related to:

- Issues about the scope of coverage for health care services;
- Medical Necessity of services requested;
- Denial of care/services/claim; or
- Other Adverse Benefit Determinations, as defined in this Section.
Appellant: The Member or the following persons may be considered an Appellant: (1) the individual authorized by the Member in writing to act on the Member’s behalf for the appeals process or; (2) the Member’s spouse, parent, committee, legal guardian, or other individual authorized by law to act on the Member’s behalf if the Member is not a minor but incompetent or incapacitated. An Appellant is a person eligible to file an Independent External Appeal.

Authorized Representative: An Authorized Representative is an individual authorized in writing by the Member or state law to act on the Member’s behalf in obtaining claim payment or during the Appeal process. A Participating provider may always act on the Member’s behalf. A Non-Participating provider may also act on the Member’s behalf with the Member’s express written consent.

Complaint: A Complaint is communication of dissatisfaction about the quality of service or benefit or other issue which is not an Adverse Benefit Determination. Complaints do not involve utilization review decisions. The complaint procedures give Members the opportunity to ask Southern Health to review any matter.

Expedited Appeal: An Expedited Appeal is an appeal for which a requested service requires Preauthorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-Expedited Appeal time frames could seriously jeopardize the Member’s life or health, or in the case of a pregnant Member, the Member’s unborn child; or the Member’s ability to regain maximum function. In determining whether an appeal should be expedited, Southern Health must apply the judgment of a Prudent Layperson who possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving (a) care that the treating physician deems urgent in nature; (b) the treating physician determines that a delay in the care would subject the Member to severe pain that could not adequately be managed without the care or treatment that is being requested; or (c) the Member is a cancer patient and the delay would subject the Member to pain. Such appeals may be made by telephone, facsimile or other available similarly expeditious method. These appeals may also be called urgent care appeals.

Independent External Review: If the Member receives a final Adverse Decision of an Appeal, the Member or the Member’s Authorized Representative, which may include the treating provider, may appeal the Adverse Decision to the Bureau of Insurance for an Independent External Review.

Physician Advisor: A Physician Advisor is a physician licensed to practice medicine in Virginia or under a comparable licensing law of a state of the United States and who provides advice regarding the Medical Necessity of a service to Southern Health as part of its utilization review activities.

Post-service Appeal: A Post-service Appeal is an appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

Pre-service Appeal: A Pre-service Appeal is an appeal for which a requested service requires Preauthorization, an Adverse Benefit Determination has been rendered, and the service has not been provided.

Reconsideration: A review of an Adverse Decision by either Southern Health’s Medical Director, a Physician Advisor, a peer of the treating provider who is licensed in the provider’s same or similar specialty, or a panel of other appropriate health care providers with at least one Physician Advisor or peer of the treating health care provider on the panel. The Member, a provider, or the Member’s Authorized Representative may request a Reconsideration.
Reconsiderations are a voluntary option in Southern Health’s appeal process. A Member is not required to go through the reconsideration process before filing an appeal.

**Complaints**

If You have a concern regarding a person, service, the quality of care, or the contractual benefits, You can call the toll-free number on Your Southern Health Member ID card and explain Your concern to one of our Customer Service representatives. You can also express that concern in writing at the following address:

Southern Health Services, Inc.
Attention: Customer Service Department
P.O. Box 7135
London, Kentucky 40742

Complaints must be received within 90 calendar days of the date written notification of the issue that is the basis of the complaint or of the incident that gave rise to the complaint was received. All complaints will be initially addressed at staff level.

**Communication and Resolution**

A complaint that involves a physician or other contracted provider will require information from that provider in the resolution of the complaint. Complaints involving an institutional or ancillary provider will be forwarded to the provider for review through the provider’s internal appeal process. Southern Health will monitor the provider’s resolution process and will require the provider to keep Southern Health abreast of its decision.

General complaints about providers (i.e., matters involving interactions with office staff or referral matters), quality of care, treatment, or provider access complaints are forwarded to Southern Health’s Quality Improvement Staff. Complaints related to administrative issues or coverage decisions where Medical Necessity is not an issue are handled by Customer Service. If the complaint is not valid according to the applicable contract, a staff representative will contact the Member or the Member’s Authorized Representative to explain Southern Health’s position. If the concern is valid according to the applicable contract, a staff representative will respond with a description of the corrective action that will be taken and initiate the appropriate steps to implement the action with the Provider.

Complaint determinations will be made within 30 calendar days of receipt of the complaint. Complaint records will be maintained for no less than five years.

**Appeals**

Appeals should be sent to the Appeals Coordinator at the following address:

Southern Health Services, Inc.
Attention: Appeal Coordinator
9881 Mayland Drive
Richmond, VA 23233
(800) 627-4872  Fax Number: (804) 747-8836

The appeal must include the following:
- Member’s name and mailing address
- Provider’s name
- Date of the service if the service has already been provided, or if the service has not yet been provided, a description of the service for which Preauthorization was requested and denied
- An explanation of why Southern Health should consider reversing our original decision
A copy of any information that will support the Member’s request
In cases where the Member’s Authorized Representative is appealing on the Member’s behalf, a completed Southern Health Authorized Representative form.

Appeals of Administrative Adverse Benefit Determinations

Level I Appeals
Level I administrative Appeals must be received within 180 calendar days of the date the Member receives notification of the denial. A letter notifying the Member that the appeal has been received will be sent within five working days of its receipt.

A First Level Appeal Committee consisting of one to three Southern Health or Coventry Health Care departmental managers or their designated representatives will review appeals of Adverse Administrative Decisions. None of these individuals will have been involved in the initial decision. If the appeal is a Pre-service Appeal, the Appellant will be notified of the First Level Appeal Committee’s decision within 15 calendar days of the date Southern Health received the appeal request. If the appeal is a Post-service Appeal, the Appellant will be notified of the First Level Appeal Committee’s decision within 30 calendar days of the date Southern Health received the appeal request.

Level II Appeals
For both Pre-service Appeals and Post-service Appeals of Adverse Administrative Decisions, if the Appellant is not satisfied with the Level I appeal decision, he or she may request in writing a Level II appeal within 31 calendar days of the date the Member received the notice of the Level I appeal decision.

The Second Level Appeal Committee is comprised of one to three members of the Southern Health or Coventry Health Care director level or above management staff. For Pre-service Appeals, Level II appeal hearings will be held and decision letters sent within 15 calendar days of the date Southern Health received the second level appeal request. For Post-service Appeals, Level II appeal hearings will be held and decision letters sent within 30 calendar days of the date Southern Health received the second level appeal request. In both cases, decision letters will be sent no later than five working days after the decision was made. During the second level appeal hearing process, the appellant has the opportunity to provide additional information or to have the case reviewed based on the already available written documentation. This level constitutes the final attempt at resolution within the Southern Health Member Administrative Complaint and Appeal Procedures.

Adverse Decisions; Decisions Involving Utilization Review/ Medical Judgment Decisions
In cases where an Adverse Decision is rendered, the medical aspect of the decision will be reviewed to determine Medical Necessity or Experimental/Investigational. To assist in making a Medical Necessity or Experimental/Investigational determination, Southern Health has developed standards and criteria that are objective, clinically valid, and compatible with established standards of health care. These standards also conform to certain criteria required by the State Corporation Commission and the Virginia Department of Health. If the Member would like to review the complete utilization review procedures, please contact Customer Service. The Member’s compliance with any portion of the utilization review process is not a guarantee of benefits or payment.

Reconsideration of an Adverse Decision
If a Member is dissatisfied with an Adverse Decision, he or she may request in writing an optional Reconsideration of the Adverse Decision or may choose to move directly to an appeal of
an Adverse Decision. Should the Member choose to request a Reconsideration of an Adverse Decision, the Member still has a right to appeal as described below.

Requests for Reconsideration must be received within 90 calendar days of the date of the initial notification of the denial. The request for Reconsideration should be sent to the same address as listed for appeals.

If the Member or the Member’s Authorized Representative chooses to request a Reconsideration of a Medical Necessity determination, a decision is made by either Southern Health’s Medical Director, a Physician Advisor, a peer of the treating provider who is licensed in that provider’s same or similar specialty, or a panel of other appropriate health care providers with at least one Physician Advisor or peer of the treating health care provider on the panel. Notice of the decision will be provided to the Member or the Member’s Authorized Representative and the Member’s provider in writing within two working days of the decision, but no longer than 10 working days following Southern Health’s receipt of the request. This notification will include the criteria used in making the decision, the clinical reason for the Adverse Decision, alternate length of treatment of any alternate treatment recommended, and the ability to appeal this decision.

**Appeals of an Adverse Decision**

If the Member is not satisfied with Southern Health’s Adverse Decision or with the outcome of the Reconsideration, the Member or the Member’s Authorized Representative may request an appeal within 180 calendar days of the date the Member received the notice of the initial Adverse Decision.

The appeal will be reviewed by a panel that includes a Physician Advisor or peer of the treating provider who is licensed in that provider’s same or similar specialty and (i) did not take part in any of the previous reviews; (ii) is not employed by nor a director of Southern Health; and (iii) is either licensed in Virginia as a peer of the treating provider or under comparable law in a state within the United States as a peer of the treating provider.

For Pre-service Appeals, the Appellant and the treating provider will be notified of the results of this review within 30 calendar days of the date Southern Health received the request for the appeal.

For Post-service Appeals, the Appellant and the treating provider will be notified of the results of this review within 60 calendar days of the date Southern Health received the request for the appeal. Any final Adverse Decision will state the criteria used and the clinical reason for the decision. The Member has the right to request the criteria which will be provided at no cost to the Member.

**Expedited Appeals**

When appropriate, the Member or the Member’s Authorized Representative may request an Expedited Appeal. Southern Health will immediately notify the Appellant of the decision to deny a request for Expedited Appeal of an Adverse Decision by telephone or facsimile and advise the member of the right to file a request for a Reconsideration or an Appeal. Notification will also include a discussion of the right to file a request for an Expedited Appeal of a final Adverse Decision with the Bureau of Insurance. This notification will be followed within 24 hours by written notice of the decision and the right to file a request for an Expedited Appeal of a final Adverse Decision with the Bureau of Insurance to the Appellant and the treating provider. The notice will include the appropriate forms by which an appeal may be filed with the Bureau of Insurance.

If Southern Health determines that it will consider the Expedited Appeal, the decision will be made within one working day after receipt of all information needed to make the decision, and no
later than 72 hours of the time of the request regardless of whether or not all required information
has been received. However, a case relating to prescriptions for the alleviation of cancer pain
shall be determined in 24 hours or less from the time of the request.

Independent External Review of Final Adverse Decisions
The Member or a provider that has the Member’s consent may appeal to the Virginia Bureau of
Insurance for review of any final Adverse Decision regarding determinations of Medical
Necessity or Experimental/Investigative guidelines when the actual cost to the Member exceeds
$300, and: (a) when all internal appeals have been exhausted, (b) when the Member requests an
expedited appeal and Southern Health determines that the standard appeals timeframe should
apply, or (c) when an expedited appeal is reviewed on an expedited basis and denied. The
Virginia Bureau of Insurance may require a $50 fee or such other amount as may be required by
the Virginia Bureau of Insurance. However, the fee may be waived or refunded for good cause
shown. Information on the External Review process is sent with the final adverse decision letter.
The decision resulting from the External Review will be binding on both the Member and
Southern Health to the same extent to which we would have been bound by a judgment entered in
an action of law or in equity.

Member’s Rights Under ERISA
If You are a participant or beneficiary of an employee welfare benefit plan under ERISA, You
may have the right to bring a civil action under ERISA Section 502(a) after completing the
Southern Health appeal process described above. Please request from Your employer Your
Summary Plan Description for a complete statement of Your rights.

Exercising the Member’s right to an appeal or Independent External Review as discussed in this
Section 5 does not affect the Member’s ability to bring civil action under Section 502(a) of the
Employee Retirement Income Security Act of 1974 (ERISA). The final decision under civil
action will be binding even if it is different from the final decision under Southern Health’s
appeal process or the Independent External Review decision.

Managed Care Ombudsman
If the Member has any questions regarding an Appeal or grievance concerning the health care
services requested or received by the Member, which have not been satisfactorily addressed by
Southern Health, the Member may contact the Office of the Managed Care Ombudsman for
assistance at the following:

Address: Office of the Managed Care Ombudsman
          Bureau of Insurance
          P.O. Box 1157
          Richmond, VA 23218

Telephone: Toll-free: 1(877)-310-6560
          Richmond Metropolitan Area: (804) 371-9032

E-Mail: ombudsman@scc.virginia.gov

Virginia Department of Health, Office of Licensure and
Certification
If the Member or a provider acting on the Member’s behalf and with the Member’s consent has
complaints about Southern Health relating to quality of care, choice and accessibility of
providers, or network adequacy, the complaint department at the Office of Licensure and
Certification may be contacted at the following:
Address: Virginia Department of Health
Office of Licensure and Certification

9960 Mayland Drive, Suite 401
Richmond, Virginia 23233-1463

Telephone: Toll free: 1-800-955-1819
Richmond Metropolitan Area: (804) 367-2104

E-mail: mchip@vdh.virginia.gov
Facsimile: (804) 527-4503
Covered Benefits

The benefits covered by Southern Health are described below. Your Prescription Drug benefits are explained in a separate rider if Your group has elected a Prescription Drug Rider.

Southern Health shall make all determinations that are required for the administration of this Evidence of Coverage including determinations regarding Medical Necessity and Covered Services. Southern Health shall interpret this Evidence of Coverage, including any terms or provisions which may otherwise be or appear to be ambiguous, whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions, and interpretations made by Southern Health, and in accordance with applicable law, shall be binding upon the Member. In accordance with Section 5, the Member has the right to appeal any Adverse Benefit Determination made by Southern Health. Occasionally, Southern Health may contract with outside organizations for determination of Medical Necessity and benefit management for certain Covered Services.

Except where otherwise specifically provided herein including, but not limited to, the services discussed in Section 6, Covered Services, are limited to Medically Necessary services and supplies. In all cases, Medical Necessity is to be determined in accordance with generally accepted standards of medical care as determined by Southern Health. When documentation submitted by your physician shows a service or procedure to be Experimental/Investigational according to Southern Health established criteria, the service/procedure will not be eligible for coverage. Please contact the Customer Service Department to determine if a service or procedure may be considered experimental or investigational. You will need to know the CPT or HCPCS code which can be provided by your physician.

Covered Services are covered at the In-Network level only when provided by a Participating Provider. Covered Services provided by Non-Participating Providers are covered at the Out-of-Network benefit level except in the case of a Medical Emergency or if Southern Health has Preauthorized the service at the In-Network level as described in Section 3. The appropriate Preauthorizations must be obtained in order for these services to be considered Covered Services at any level, even when Southern Health is the secondary carrier. Refer to the Preauthorization list for specific services that require Preauthorization. A current Preauthorization list may be obtained from the Southern Health website or by calling Customer Service.

Behavioral Health and Substance Abuse
Southern Health contracts with an outside vendor to coordinate and Preauthorize the diagnosis and treatment of all substance abuse and psychiatric conditions covered under this benefit. The Preauthorization for behavioral health and substance abuse care (inpatient and outpatient) must be obtained through the contracted vendor and is required for both the In-Network and Out-of-Network level of benefits. Southern Health Customer Service will not be able to Preauthorize behavioral health or substance abuse services or answer questions regarding claims receipt or payment. If Preauthorization from the behavioral health vendor is not received, services will be denied.

When care is being received from Participating Providers, In-Network benefits apply. When care is being received from Non-Participating Providers, Out-of-Network benefits apply.
Coverage is dependent upon the establishment of Medical Necessity for the care. If the inpatient or outpatient service or a portion thereof is determined not to be Medically Necessary, the provider will be notified that services are not Covered Services or that coverage will cease. In a situation where the Member will be responsible for the charges, the Subscriber or a family member will be notified that coverage will cease.

What is covered
- **Outpatient visits** to providers as may be necessary and appropriate for short-term evaluative or crisis intervention services. This includes medication management visits to monitor and adjust drugs prescribed for a psychiatric condition. Family counseling is covered if provided in conjunction with the treatment of a covered Dependent under the age of 19.
- **Inpatient care (Acute or Partial Hospitalization)** at a facility.
- **Psychological or Neuropsychological Testing**.

Coverage for treatment for Biologically-Based Mental Illness will be the same as coverage under the medical and surgical benefits for any other illness, condition, or disorder. Your payment responsibility and any applicable Benefit Maximum will depend on the place of service. You should consult the Schedule of Benefits to determine the amount of Your payment responsibility per visit and any applicable Benefit Maximum.

**Complex Case Management**
Southern Health strives for the early identification and effective management of selected members for whom intensive management can be expected to improve the quality of care and reduce overall medical expenses. The Complex Case Management Program offers special assistance to Members with serious and complex, long-term medical needs and promotes quality of care to reduce the likelihood of extended, more costly health care. Southern Health identifies serious and complex medical conditions as ones that are persistent and substantially disabling or life-threatening and that require treatments and services across a variety of domains of care to ensure the best possible outcome for each unique member. Long-term medical needs are those that are more chronic than acute and can be expected to require extended use of health care resources.

Complex Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual Member’s health care needs through communication and available resources to promote quality, cost-effective outcomes. Members are identified by various methods, including, but not limited to, claims or encounter data, hospital admission or discharge data, laboratory data, pharmacy data, and employer group, physician and self-referral. You have the option to opt in by self-referral by calling the Customer Service Department or if You chose not to participate, You may opt out by calling the Customer Service Department or speaking with a case manager. If you have questions about the case management programs or would like to speak with a case manager, call the customer service number on the back of your Member ID card.

**Disease Management**
Southern Health provides disease/health management for conditions that can be improved through active management. Our aim is to proactively reach out to members and engage them in managing their health, by emphasizing prevention through education, supporting the physician-patient relationship and reinforcing compliance with their physician’s care plan. Members are identified by various methods including, but not limited to, claims, pharmacy, laboratory, physician and self-referral. You have the option to opt in by self-referral by calling the Customer Service Department or if You choose not to participate, You may opt out by calling the Customer Service Department or speaking with a disease management staff member. If you have questions
Emergency Benefits

A Medical Emergency is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson to result in (i) serious jeopardy to the mental or physical health of the Member; (ii) danger of serious impairment of the Member’s bodily functions; (iii) serious dysfunction of any of the Member’s bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Screening and stabilization services provided in a hospital emergency room for a Medical Emergency may be received from either Participating or Non-Participating Providers and are not required to be Preauthorized.

A Prudent Layperson is someone without medical training who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent Layperson will be considered to have acted “reasonably” if other similarly situated Laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

Southern Health reviews all information and documentation with respect to Your claim in accordance with established medical criteria and guidelines. If this review results in the determination that You did not experience a Medical Emergency, You may be responsible for the entire bill. Claims resulting from a Medical Emergency are eligible for payment at the In-Network level of benefits. If Your claim is denied or paid at the Out-of-Network benefit level when You believe a Medical Emergency existed, contact Southern Health’s Customer Service Department.

Some examples of a Medical Emergency include, but are not limited to:

- Severe or unusual bleeding
- Severe burns
- Trouble breathing
- Seizures or Convulsions
- Suspected poisoning
- Broken bone
- Any vaginal bleeding in pregnancy
- Unconsciousness
- Chest pain

Procedures

If You believe a Medical Emergency exists, You should immediately call 911 or go directly to the nearest hospital emergency room. Whenever possible, consult Your treating physician if You believe You are experiencing a Medical Emergency. Your treating physician or a physician on-call for Your treating physician can be reached 24 hours a day. To be eligible for the In-Network level of benefits, once You are stabilized, follow-up care resulting from a Medical Emergency must be provided by a Participating Provider or Preauthorized by Us.

Dependents residing outside of the Service Area on a temporary or permanent basis are subject to all of the coverage provisions and limitations described in this Section.

The following services are covered when You experience a Medical Emergency:

- **Covered Services provided by Non-Participating Providers**: only if seeking care from a Participating Provider could reasonably be expected by a Prudent Layperson to cause the Member’s condition to worsen if left unattended.
- **Covered Services provided by Participating Providers**.
- **Emergency inpatient hospitalization**: If You are admitted as an inpatient to a non-participating hospital as the result of a Medical Emergency, You must notify Southern
Health by calling the Customer Service number on Your Member ID card within 24 hours. If You are incapacitated and unable to contact Southern Health, You must make arrangements for Us to be notified as soon as medically possible. After admission to a non-participating hospital in an emergency, once You are clinically stable, in order to continue receiving services from a Non-Participating Provider at the In-Network level of benefits, You must have these services Preauthorized.

♦ **Emergency room visits to a Participating hospital:** If You are treated and released, You will be responsible for the amount of Your payment associated with an emergency room visit. If You are admitted to the hospital through the emergency room, Southern Health will waive the emergency room Copayment. Consult the Schedule of Benefits to determine the amount of Your payment responsibility.

♦ **Emergency room visits to non-participating hospitals:** only when the delay in receiving care from a Participating hospital could reasonably be expected by a Prudent Layperson to cause the Member’s condition to worsen if left unattended or if the Member is incapacitated and unable to select a Participating facility.

♦ **Physician or hospital care while out of the Service Area or country:** for acute illnesses and injuries outside of the Service Area or country when the Member could not return to the Service Area for treatment, the treatment was a Medical Emergency, Medically Necessary, and the Member was out of the Service Area for reasons other than obtaining medical care.

### Inpatient Hospital Care

Inpatient hospital care requires Preauthorization from Southern Health unless the admission is the result of a Medical Emergency. For information on what to do if You are admitted to the hospital as the result of a Medical Emergency, please see [Emergency Benefits](#) in this Section. Failure to obtain a Preauthorization for a non-emergent inpatient admission will result in a denial of coverage.

Consistent with the Utilization Review Policy of Southern Health, all hospital admissions and continued stays are reviewed during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care in question. If the hospital stay or portion thereof is determined not to be Medically Necessary, the provider will be notified in writing that coverage will cease. In a situation where the Member will be responsible for the charges, the Subscriber or a family member will be notified in writing that coverage will cease.

Your payment responsibility for an inpatient admission is shown in the Schedule of Benefits. All Medically Necessary services for a hospital admission as described above are covered after any applicable Deductible, Copayment, and/or Coinsurance. When a Member is admitted to a Participating hospital and is under the care of a Non-Participating Provider, only the hospital charges will be eligible for the In-Network level of benefits.

**Coverage for inpatient hospital care includes but is not limited to:**

**Maternity:** We will cover a minimum of 48 hours of inpatient care following a vaginal delivery or a minimum of 96 hours of inpatient care following a cesarean delivery. The mother and her newborn child may be discharged earlier than the minimum length of stay if the decision to discharge is made by an attending physician in consultation with the mother.

**Medications:** On an inpatient basis, that are prescribed to treat a covered indication if the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-reviewed Medical Literature. This includes cancer drugs on an inpatient basis that are FDA approved for use in the treatment of cancer and that have been recognized in any of the Standard Reference Compendia as safe and effective for treatment of the specific type of cancer diagnosed. Any drug approved by the FDA for use in the treatment of cancer pain shall not be...
denied for coverage on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with intractable cancer pain.

**Nursery care:** Southern Health will pay for initial nursery care for newborns following delivery. Services or treatment for health conditions which arise and prolong the initial nursery stay will be considered a separate admission and require Preauthorization. The inpatient hospital Copayment listed in the Schedule of Benefits will apply. Newborns who have not been added to the plan within 31 days of birth, as explained in Section 8, are not eligible for coverage of any portion of the hospital and physician charges during the inpatient stay following birth or any subsequent services.

**Room and board:** A semi-private room and general nursing care when part of a covered inpatient stay. A private room is only covered if Medically Necessary or if a semi-private room is not available.

**Specialized care units:** Such as intensive care or cardiac care units.

**Surgical and anesthetist services and supplies, when Medically Necessary and Preauthorized.** In addition, Southern Health will cover a minimum hospital stay of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. This length of stay may be shortened if the treating physician in consultation with the patient determines that a shorter stay would be appropriate; and Southern Health will cover inpatient hospital care for at least 48 hours following a radical or modified radical mastectomy and at least 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. However, inpatient hospital care for these stated periods are not required when the attending physician in consultation with the patient determines that a shorter hospital stay is appropriate.

**New Technology**
Southern Health strives to remain current in evaluating new and existing technologies for inclusion as a Covered Service. Southern Health continually assesses and reviews clinical literature to evaluate new technologies. Prior to an acceptance as a Covered Service, Southern Health confirms that the appropriate regulatory body has assessed any new or existing technology to be covered in cases where that assessment is required by law. New and existing technologies to be considered Covered Services must, based on clinical evidence reported by Peer Reviewed Medical Literature, demonstrate a marked improvement in health outcomes, health risks, and health benefits when compared with established procedures and products.

**Preventive Care**
Southern Health has adopted preventive health recommendations for our Members to promote preventive health services. These guidelines are based on the recommendations of national medical associations and leading health organizations and have been approved by independent physicians practicing in the Southern Health Service Area who participate on Southern Health’s Clinical Quality Improvement Committee. Members have access to these guidelines through the Southern Health website and are sent a copy of these guidelines upon request.

Preventive care services are covered at the In-Network level of benefits only when Covered Services are received from Participating Providers. For certain services, Southern Health may require that care be received from specific Participating Providers in order to receive the In-Network level of benefits. Participating Providers may not be considered participating for all services they are able to offer patients. Participating Providers are aware of these services. When Medically Necessary, the following preventive, diagnostic and treatment services are covered:
**Colorectal cancer screening:** Specific screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

**Hearing and vision screenings:**
- For children up to age 18 when performed by a general practitioner, family practice physician, pediatrician, or internist.
- Newborn infant hearing screenings and all necessary audiological examinations provided in a hospital. The infant hearing screenings and all necessary audiological examinations must use FDA approved technology that is recommended by the Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Follow-up audiological examinations as recommended by the infant’s physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss are also covered.

**Immunizations:** Routine and necessary immunizations and boosters including, but not limited to, diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, HiB, varicella and other such immunizations as may be prescribed by the Virginia Commissioner of Health.

**Mammogram:** One baseline screening for ages 35 to 39; One mammogram annually for ages 40 and over.

**Office visits:** for preventive care, including well-baby care and periodic check-ups according to the Preventive Care Guidelines established by Southern Health. Participating Providers have access to these guidelines. Members have access to these guidelines through Southern Health’s website at www.southernhealth.com and are sent a copy of these guidelines upon request.

**Pap Smear:** Annual testing performed by any FDA approved gynecologic cytology screening technologies.

**PSA (Prostate Specific Antigen) Test:** One test in a 12 month period and digital rectal examinations, all in accordance with American Cancer Society guidelines for (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society.

**Treatment of illness or Injury**
Diagnosis and Medically Necessary treatment of illness or injury includes:

**Allergy Treatment:** Allergy testing, diagnosis and Medically Necessary treatment.

**Ambulance:** Ambulance services are covered in the event of a true Medical Emergency. Limited non-emergency ambulance services are covered when Medically Necessary and must be Preauthorized by Us.

**Anesthesia:** Anesthesia administered as part of a Covered Service.
- Hospital services and general anesthesia for dental procedures are covered when determined to be Medically Necessary for a Member who is under the age of five, is severely disabled, or has a medical condition, and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. Preauthorization of hospitalization and anesthesia should not be construed as Preauthorization and payment of dental care incidental to the hospitalization and anesthesia benefits.
Blood:
- Blood and plasma processing fees.
- Costs associated with drawing, preparation, and storage of Member’s blood, blood plasma, or blood derivatives for use by the Member.
- Charges incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Covered charges include the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

Cardiac rehabilitation: Cardiac rehabilitation is covered according to coverage guidelines used by Southern Health. Please consult Your Schedule of Benefits for any Benefit Maximum.

Chemotherapy: Chemotherapy is covered when Medically Necessary and may be administered in an inpatient or outpatient setting. Your cost sharing will be the appropriate Deductible, Copayment or Coinsurance listed on Your Schedule of Benefits based on the place of service.

Clinical Trials:
- Clinical Trials for Treatment Studies on Cancer, including ovarian cancer trials, are covered as described in this Section. Medically Necessary Covered Services that are incurred by the Member as a result of the treatment being provided for purposes of a clinical trial are referred to as patient costs in this Section. Patient costs incurred during Phase II, Phase III, or Phase IV clinical trials for treatment studies on cancer approved by the National Cancer Institute (NCI), an NCI cooperative group or an NCI center, the FDA in the form of an investigational new drug application, the Federal Department of Veterans Affairs, or an institutional review board of an institution in Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI are covered. The facility and personnel where this treatment is provided must be capable of such provision of care by virtue of their experience, training, and expertise. Phase I clinical trials are not covered.
- Coverage under this Section shall only apply if: (i) there is no clearly superior, non-investigational treatment alternative, (ii) the available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative, and (iii) the Member, Member’s treating physician or other treating provider conclude that the Member’s participation in the clinical trial would be appropriate, pursuant to procedures established by Southern Health and disclosed in this Evidence of Coverage. Non-health care services that a Member may receive as a result of this treatment, costs related to managing the research associated with the clinical trial, and investigational drugs and devices are not covered. Your payment responsibility for this coverage will relate to the place of service where services are received.

Consultations: Appointments with Specialists and/or appointments for second opinions for Covered Services.

Dental Injury: Southern Health provides benefits for Medically Necessary dental services as a result of accidental injury if treatment is sought within 60 days of the accident for injuries occurring on or after the effective date of coverage. If the accidental injury occurred prior to your effective date with Southern Health, the 60-day timeframe will be waived. Southern Health will review Your claim for dental injury in accordance with established medical and dental guidelines. If this review results in the determination that the services You received were not Medically Necessary, then You may be responsible for the entire bill. Call Customer Service at the number on Your Member ID card to request treatment.
Diabetes Treatment:

- Diabetes counseling is covered for in-person outpatient self-management training and education, including medical nutritional therapy required for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin using diabetes. This coverage is provided if: (i) prescribed by a provider legally authorized to prescribe such services under law, and (ii) provided by a provider who is a certified, registered, or licensed health care professional.

- Diabetes supplies including insulin pumps and insulin pump supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are provided if prescribed by a provider legally authorized to prescribe such items under law.

Dialysis: Peritoneal Dialysis and Hemodialysis is covered when Medically Necessary and may be administered in an inpatient or outpatient setting. Your cost sharing will be the appropriate Deductible, Copayment or Coinsurance listed on Your Schedule of Benefits based on the place of service.

Durable medical equipment (DME):
DME is non-disposable equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose. This equipment is appropriate for use in the home and is generally not useful in the absence of the illness or injury for which it is used. DME is not primarily for the convenience of the caregiver. Southern Health will cover rental or, at the sole option of Southern Health, purchase of Medically Necessary DME, such as wheelchairs, crutches, walkers, hospital beds and apnea monitors. Repair, replacement, and duplication are not covered if due to loss, neglect, abuse of equipment, or for the convenience or personal preference of the Member. Please consult Your Schedule of Benefits for the Benefit Maximum.

- Ostomy supplies are covered under this benefit and will accrue toward the DME Benefit Maximum.

- Equipment rental for Negative Pressure Wound Therapy is covered under this benefit and does not apply to any DME Benefit Maximum.

- Orthotics are covered under this benefit and will accrue toward any DME Benefit Maximum. Covered orthotic devices must, (i) be a device added to the body to stabilize or immobilize a body part, prevent deformity or assist with function; and (ii) be semi-rigid and correct a diagnosed musculoskeletal malalignment of a weakened or diseased body part; or (iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part. Foot orthotics are not covered.

- Oxygen and Respiratory equipment are covered under this benefit.

- Wigs for patients of chemotherapy or radiation therapy are covered under the DME benefit; however, the benefit for such wigs is limited to a maximum purchase price of $250 per Benefit Year. This maximum for wigs contributes to any DME Benefit Maximum.

Early intervention services: Early intervention services are provided for Dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for such services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. Section 1471 et seq.). Early intervention services are Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices. In certain circumstances, services that are not ordinarily Covered Services are considered Covered Services when they are identified on the Individualized Family Service Plan. Any Copayment, Coinsurance, or Deductible required for these services may be paid through the use of federal Part H program funds, state general funds, or local government funds appropriated to implement Part H services for families who may refuse the use of their health care coverage to pay for early intervention services due to their payment responsibility. Consult Your Schedule of Benefits for Your Benefit Maximum.
**Eye:** Diagnosis and Medically Necessary treatment of diseases and injuries of the eye to include the first pair of cataract lenses or glasses following cataract removal surgery or lenses for the treatment of Keratoconus.

**Genetic Testing and Genetic Counseling:** Genetic testing, screenings, counseling, and subsequent prophylactic procedures when Medically Necessary and not specifically excluded by Southern Health.

**Home health care services:** are covered when ordered by Your physician and the attendance of a skilled professional nurse is required to perform the care. Each visit by a registered nurse or a licensed practical nurse to provide nursing care or by a physical therapist, occupational therapist, or speech therapist will be considered one visit. Only visits by licensed professionals are covered. Homemaker services, home health aide services, custodial care (including outpatient custodial care), respite care, and private duty nursing are not covered. Consult Your Schedule of Benefit for Your Benefit Maximum.

**Home visits:** by a physician for Covered Services.

**Hospice Care:** Hospice Care is covered for Members who have been diagnosed with a terminal illness and have chosen to receive palliative care only. Hospice patients may be managed through the Complex Case Management Program to assist with palliative and supportive physical, psychological, and psychosocial care and other health services for Members with a terminal illness. Inpatient hospice respite care is covered for up to five days in a six month period. Hospice care involves a program of home and inpatient care provided directly or under the direction of a licensed hospice. A terminal illness is a condition that has been diagnosed as terminal by a licensed physician and the medical prognosis is a life expectancy of six months or less.

**Hospital Based Physicians:** Coverage for services received from hospital based physicians are covered when Medically Necessary. Your cost sharing will be the appropriate Deductible, Copayment or Coinsurance listed on your Schedule of Benefits based on the place of service and type of service. Hospital based physician services such as anesthesiology, radiology and pathology rendered by Non-Participating Providers will be paid according to Southern Health's Allowable Charge policy. To inquire about specific services and the applicable Out-of-Network rate or to obtain a copy of Southern Health's Allowable Charge policy contact the Customer Service Department.

**Implanted Devices:** Surgically implanted devices. This includes but is not limited to implanted or soft lenses when replacing an injured lens.

**Infertility:** Infertility is the inability to conceive after one year of intercourse without contraception. Diagnostic services to establish and identify the cause of infertility are covered.

**Infusion Therapy:** Infusion therapy includes but is not limited to therapeutic injections, chemotherapy and dialysis. Infusion therapy is covered when Medically Necessary and may be performed in an inpatient, outpatient, or home setting. Your cost sharing will be the appropriate Deductible, Copayment or Coinsurance listed on Your Schedule of Benefits based on the place of service.

**Inhalation therapy.**

**Injectables:** Therapeutic drugs are covered when FDA approved, Medically Necessary and administered in an inpatient setting or as the reason for a visit to an outpatient facility or physician’s office. Your cost sharing will be the appropriate Copayment based on the place of
service. Additional charges may apply if the drugs are shipped directly to You as indicated on the Schedule of Benefits. Self-Administered Injectable Drugs, except Insulin, are NOT covered unless You have a Prescription Drug Rider that provides coverage for Self-Administered Injectable Drugs.

**Laboratory Tests:** In-Network benefits apply when obtained at the office of a participating physician or through a participating laboratory listed in the Directory of Health Care Providers.

**Lymphedema:**
- Treatment of Lymphedema is covered including equipment, supplies, complex decongestive therapy, and outpatient self-management training and education if prescribed by a health care professional legally authorized to prescribe or provide such items under law.
- Equipment and supplies for the treatment of Lymphedema are subject to any DME Benefit Maximums and/or Copayment/Coinsurance amounts as listed in the Schedule of Benefits.
- Outpatient self-management training and education for the treatment of Lymphedema will be handled as part of the rehabilitation therapy benefit and is subject to any Benefit Maximums, and Copayment/Coinsurance amounts listed in the Schedule of Benefits for rehabilitative services.

**Maternity:** Obstetrical care, including prenatal, delivery, and postpartum care, in an inpatient setting and/or a home visit or visits in accordance with the medical criteria outlined in the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the “Standards for Obstetric-Gynecologic Services” prepared by the American College of Obstetricians and Gynecologists. A nurse midwife may provide obstetrical care. Obstetrical care does not include services for childbirth performed in a home setting.

**Medical Supplies:** Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of the illness or injury. Covered medical supplies include, but are not limited to, the following items: catheters, irrigation trays, oxygen tubing, urinary bags, some surgical dressing, and disposable items prescribed by a physician, that are used as part of covered DME. The medical supply benefit is limited to a maximum per Benefit Year as described in the Schedule of Benefits. This maximum for medical supplies is combined with any benefit maximum for DME. Some Medical Supplies do not apply to the DME Benefit Maximum. Contact Customer Service to determine if a specific supply applies to the DME Benefit Maximum.

**Neuro-psychological Testing** when Medically Necessary and Preauthorized.

**Oral surgery:**
- Nondental surgical and hospitalization procedures incidental to fractures of the jaw, excision of tumors, and for congenital defects, such as cleft lip and cleft palate.
- Excision of partial or complete bony impacted third molars. Anesthesia services rendered in connection with the covered removal of impacted teeth are also covered if performed by a person licensed to do so.
- Examination, evaluation, and Medically Necessary treatment of temporomandibular joint (TMJ) pain dysfunction and myofacial pain dysfunction (MPD).
- Surgery that is required to treat a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part is covered.

All other procedures involving the teeth or areas surrounding the teeth are not covered.
**Prosthetic devices**: are covered, except for charges for repair, replacement, or duplication if due to loss, neglect, abuse of device, or if for the convenience or personal preference of the Member.

**Radiation Therapy** is covered when Medically Necessary and may be performed in an inpatient or outpatient setting. Your cost sharing will be the appropriate Deductible, Copayment or Coinsurance listed on Your Schedule of Benefits based on the place of service.

**Reconstructive surgery**: Reconstructive surgery or procedures when performed to correct deformity caused by disease, trauma, or a previous therapeutic process that is considered a Covered Service. In the event a Member is undergoing a multi-stage reconstruction or fulfilling a specific waiting period that is medically indicated, then the Provider must submit a treatment plan for approval.

Pursuant to the Women’s Health and Cancer Rights Act, if You elect reconstructive surgery in connection with a mastectomy, Southern Health will provide benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas;

Such services shall be performed in a manner determined in consultation with the attending physician and the patient.

Additionally, Southern Health provides benefits in connection with reconstructive breast surgery for:

- Nipple and areola reconstruction.
- Medical complications resulting from the rupture of the prostheses/implant, and appropriate treatment, including removal of the prostheses/implant, upon Preauthorization.

**Short-term rehabilitative therapy**: Short-term rehabilitative therapy is covered when Medically Necessary. In the event of an inpatient stay for rehabilitation, the amount of Your payment responsibility associated with an inpatient hospital stay will apply. Consult Your Schedule of Benefits for Your Benefit Maximum.

Speech therapy is limited to services to correct a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment. Conditions resulting from functional nervous disorders are not covered.

Occupational therapy and physical therapy are limited to services that assist the Member to achieve and maintain self-care and perform other activities of daily living.

**Skilled Nursing Facility Confinement**: Benefits are provided when Skilled Nursing Care is Medically Necessary. Custodial care, respite care, rest cures, domiciliary, or convalescent care are not covered. Consult Your Schedule of Benefits Your Benefit Maximum.

**Spinal Manipulation**: Adjustment, therapeutic intervention or physical manipulation of the spine (neck, upper and lower back) is covered. Consult Your Schedule of Benefits for Your Benefit Maximum.

**Sterilization**: Sterilization is covered; however, reversal of sterilization is not covered.

**Surgical procedures**: Surgical procedures may be performed in an inpatient or outpatient setting.

**Termination of pregnancy**: Termination of pregnancy during the first trimester is covered, except in the case of multifetal pregnancy reduction. Multifetal pregnancy reduction is only
covered if the life or physical health of the mother or fetuses would be endangered if the fetuses were carried to term. Termination of pregnancy after the first trimester is a Covered Service only if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term or if fetal abnormalities are detected. The first trimester is considered to be the first 13 weeks of pregnancy.

**Transplants**: Services related to Medically Necessary organ, tissue and bone marrow transplants, when Preauthorized by Southern Health and performed at a Coventry Transplant Network Participating Facility. This includes treatment of breast cancer by autologous bone marrow or stem cell transplants. Your physician must call Southern Health to have all services, consults, evaluation and testing relating to a prospective transplantation Preauthorized. All potential transplant cases are assigned a complex case manager to coordinate and Preauthorize all necessary care.

Donor screenings are covered and are subject to a lifetime Benefit Maximum of $10,000 when performed at a Coventry Transplant Network Participating Facility.

If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a Southern Health Member will be covered for the duration of the contract of the Member when approved by Southern Health. The cost of any care, including complications, arising from an organ donation by a Member when the recipient is not a Southern Health Member is excluded.

Travel expenses for Members and living donors are covered according to Southern Health’s transplant travel benefit. Members are covered when Southern Health is the primary insurer and a Coventry Transplant Network Participating Facility is used.

Southern Health uses a transplant network. Facilities in this network are contracted to perform specific transplant services. Southern Health reserves the right to require the Member to obtain services from a contracted provider who may be outside of the Service Area if the services are to be covered by Southern Health at the In-Network benefit level. Organ, tissue, and bone marrow transplants performed by a Non-Participating Provider will be subject to the Out-of-Network benefit level and may be limited to a maximum benefit as described in the Schedule of Benefits. Any procedures involving organ and tissue donor expenses when the recipient is a covered Southern Health Member are also limited to any applicable maximum benefit when performed Out-of-Network.

**X-rays**: X-rays and diagnostic procedures. Refer to Section 3 for diagnostic procedures that require Preauthorization.

**Urgent Care Benefits**

Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as a Medical Emergency but requires prompt medical attention. Your PCP can help You determine whether or not You need to receive care at an Urgent Care center.

Southern Health will review Your claim for Urgent Care in accordance with established medical criteria and guidelines. If this review results in the determination that You did not require Urgent Care, You may be responsible for the entire bill.
Non-Covered Services

Southern Health does not cover any service or supply that is not Medically Necessary or any service or supply that is not a Covered Service or that is a direct result of receiving a non-covered service. Services, supplies, equipment, facilities and related charges that are not expressly listed in Section 6, Covered Services, or excluded or limited under this Section 7, are not covered unless covered under a rider or amendment to this Evidence of Coverage.

In addition, the following services are specifically excluded:

**Administrative Examinations/Immunizations:** examinations or immunizations for employment, travel, school, camp, sports, licensing, insurance, adoption, marriage or those ordered by a third party.

**Administrative Services:** charges made to Members by providers for failure to appropriately cancel a scheduled appointment, telephone calls, completion of forms, transfer of records, copying of medical records or generation of correspondence.

**Alternative Medicine:** services or supplies related to alternative or complementary medicine. Services in this category may include, but are 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 (dance, arts, crafts, aquatic, gambling and nature therapy); and sleep therapy.

**Behavioral Health and Substance Abuse:**
- Long term Behavioral Health care
- Residential Treatment
- Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school
- Educational testing or psychological testing, unless part of a treatment program for Covered Services
- 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
- Any other services listed in this Evidence of Coverage as noncovered services that could be considered Behavioral Health services

**Blood:** drawing, preparation and storage of umbilical cord blood.

**Braces** and supports needed for athletic participation or for employment.

**Charges** which are in excess of any benefit limitations, or Benefit Maximums (e.g., number of days, etc.)

**Contraceptive** (birth control): oral or injectable contraceptive medications must be purchased from a pharmacy and are not covered unless Your employer has elected the Prescription Drug Rider.
Cosmetic treatment and surgery that is a service performed mainly to improve a Member’s appearance or for psychological benefits.

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 incurred as a result of the provision of dental services including those performed in a hospital or outpatient care facility, including:
- Dental or oral appliances or devices, including but not limited to, bite guards for teeth grinding, dental implants, dentures, and oral appliances for snoring or sleep apnea regardless of Medical Necessity.
- Dental services or related expenses incurred as a result of the provision of dental services including those performed in a hospital or outpatient care facility and treatment of diseases of the teeth or gums except as allowable as defined in Section 6.
- Oral surgery which (1) is part of an orthodontic treatment program, (2) is required for correction of an occlusal defect, or (3) is not specifically covered in this Evidence of Coverage or any amendments thereto. Shortening of the mandible or maxillae for cosmetic or orthodontic purpose, correction of malocclusion, and surgical orthodontics or orthognathics also are not covered except as stated in Section 6.
- Soft tissue impactions (wisdom tooth extraction)

Donor: procedures involving Member’s organ and tissue donors, unless the recipient is a covered Southern Health Member or as stated in Section 6. 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: Except as covered in Section 6 under “Clinical Trials”, medical, surgical or other health care procedures, services or supplies are considered Experimental or Investigational if any of the following applies:
- Is in the testing stage or in early field trials on animals or humans.
- Is under clinical investigation by health professionals or are undergoing clinical trials by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration. Any drug not approved for use by the FDA, any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature, or any drug that is classified as an Investigational New Drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA. Drugs for the treatment of a specific type of cancer that are not FDA approved will be covered when they are approved for one type of cancer for which the drug has been prescribed in any of the Standard Reference Compendia. Similarly drugs for the treatment of a specific indication that are not FDA approved will be covered so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted peer-reviewed medical literature.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval.
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered in the “Clinical Trials” section under Covered Benefits.
Section 7: Non-Covered Services

- Does not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare.
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Review Medical Literature.

**Eye:**
- Routine eye exams, refractions for eyeglasses or contact lenses, and all services associated with eyeglasses or contact lenses, unless Your group has elected the Vision Rider
- Services for, or related to, eye surgery for the purpose of correcting refractive errors such as radial keratotomy, lasik, and other refractive and laser eye surgeries or vision correction procedures; eye exercises
- Visual augmentation devices
- Vision Therapy

**Foot:**
- Services for weak, strained, flat, unstable, or unbalanced foot or for a metatarsalgia or bunion. This does not apply to an open cutting operation.
- Routine foot care including trimming of hyper keratotic lesions, calluses, and nails, except for foot care for diabetics
- Foot 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, except for genetic testing for cystic fibrosis; pre-implantation genetic testing.

**Growth Hormone**, unless Your Group has elected a Prescription Drug Rider. Please refer to Your Prescription Drug Rider for restrictions on coverage of Growth Hormone under the Rider. Growth Hormone for idiopathic short stature or for individuals over age 18 is not covered.

**Hearing Aids.**

**Infertility:** surgical or medical treatment of infertility is not covered. This includes services, office visits, lab and diagnostic tests, and procedures to promote conception once a diagnosis of infertility has been established. In the absence of a confirmed diagnosis of infertility, coverage for these services ends when drugs are prescribed or surgeries are performed to correct the condition. Treatment 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 are not covered unless Your employer has elected the Infertility Rider. Infertility services not specifically described as covered are not covered.

**Medical Equipment, appliances, devices and supplies:** Your coverage does not include benefits for medical equipment, appliances, devices and supplies that have both a therapeutic and non-therapeutic use. These include but are not limited to:
- Air conditioners
- Batteries and battery chargers, unless utilized as part of a Covered Service (e.g., insulin pumps, infusion pumps)
- Bedliners
- Breast pumps
- Canes
Section 7: Non-Covered Services

- Cervical collars
- Convenience items including, but not limited to, telephone, television, guest meals and accommodations
- Corsets
- Cranial helmets
- Dehumidifiers
- Elastic or 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 including, but not limited to, escalators, elevators, ramps, stair glides or emergency alert equipment
- Humidifiers
- Mattress covers
- Office chairs
- Office visits for the purpose of fitting a noncovered 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
- Rental or purchase of TENS units
- Splints
- Sun or heat lamps
- Take home medications
- Traction apparatus
- Tub benches
- Whirlpool baths

Medications for travel (e.g., medications for the prevention of malaria)

Newborn: hospital and physician charges for newborns for the birth and inpatient stays or any subsequent services when the newborn is not enrolled in the Plan within 31 days of birth.

Nutrition training except when part of diabetes education.

Nutritional formula or supplements, tube feeding and medical foods even if provided as the sole source of nutrition.

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.

Prescription drugs: including self-administered injectable, unless Your group has elected a Prescription Drug Rider. However, insulin is included in the medical and surgical benefit instead of the prescription drug rider if Your group has not elected a Prescription Drug Rider.

Private duty nursing.

Private room: unless Medically Necessary or if 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 elsewhere in this Evidence of Coverage.

Services or Supplies. Your coverage does not include benefits for services or supplies if they are:

- The result of injuries sustained during the commission of an illegal act
- Services rendered as a result of a Temporary Detention Order
- Services or supplies related to care for conditions which state or local law require 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
- Service and supplies for smoking cessation and nicotine addiction
- Services received following the effective date of the termination of the Member’s coverage with Southern Health.
- 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 Dysfunction, Sexual Aids or Sex Transformation: treatment for sexual dysfunction, sexual aids, or sex transformation or the reversal thereof. This includes medical and behavioral health services. Treatment of sexual dysfunction is limited to pharmacologic therapy under your Prescription Drug Rider.

Sterilization: the reversal of Sterilization.

Stockings: elastic hose, graduated compression (TED) hose, Jobst stockings.

Testicular Implants.

Therapy. The following types of habilitative or rehabilitative therapy are not covered, although this list is not meant to be exclusive:

- 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
- Physical Occupational or Speech Therapy designed specifically to return a person to work or restore vocational functions, for example, work hardening programs.

Travel and Transportation other than Medically Necessary transportation that has been Preauthorized by Southern Health.

Weight reduction: dietary supplements or programs for weight reduction. Medical or psychiatric services, office visits, and associated charges for procedures primarily performed for the treatment of obesity or weight reduction, including but not limited to, gastric bypasses, “mini” gastric bypasses, stomach stapling, gastric balloons, jejunal bypasses, gastric banding, gastroplasty, Biliopancreatic Diversion Duodenal Switch (BPD-DS), and bariatric specialist services.

Work related injuries or illnesses, including those injuries that arise out of or in any way result from an illness or injury that is work-related; provided the employer provides, or is required to provide, workers’ compensation or similar type coverage for such services.
Eligibility and Enrollment

Initial Eligibility
In order to be eligible for coverage, the Subscriber must meet the requirements to be an eligible employee as described in the Group Agreement/Policy and continue to live or work in the Southern Health Service Area.

An exception to the requirement to live or work in the Service Area is made for those Subscribers covered under COBRA. However, all Members who reside outside of the Service Area are subject to all of the coverage provisions and limitations outlined in this Evidence of Coverage.

If You wish to be covered, You must complete and submit an Enrollment/Change Form, available from Your employer, within 31 days of meeting Your employer’s eligibility requirements. Your Southern Health coverage is effective for You and Your covered family members on the effective date shown on Your Member ID cards.

Southern Health must be notified promptly of any changes in the eligibility status of all Members. An Enrollment/Change Form is available from Your employer.

Important Eligibility Information for Groups with Members Diagnosed with Breast Cancer
Southern Health shall not deny the issuance or renewal of, or cancel a contract or include any exceptions of benefits in the contract a) Solely because a Member has been diagnosed as having a fibrocystic condition or a nonmalignant lesion, solely due to family history of a Member related to breast cancer, or solely due to any combination of these factors; or b) Solely due to breast cancer, if the Member has been free from breast cancer for a period of five years or more prior to the application date for coverage. (If coverage is under a pre-existing condition exclusion period, this provision shall control as to the extent of any pre-existing condition periods for coverage.)

Routine follow-up care used to determine whether a breast cancer has recurred in a Member who has been previously determined to be free of breast cancer as evidenced by negative follow-up care for a period of at least five years following completion of local and adjuvant therapies shall not be considered to constitute medical advice, diagnosis, care, or treatment for purposes of determining a pre-existing condition unless evidence of breast cancer is found during or as a result of the follow-up care.

Uniformed Services Employment and Re-employment Rights Act (USERRA)
In accordance with Federal law, certain Employees who return to employment following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan (for themselves and any Dependents who were covered prior to military assignment). No new waiting period requirement will apply, except for any waiting period still remaining from prior to the active military assignment. However, this provision is intended to comply with the minimum requirements of the USERRA and, if it is in conflict or incomplete in any way, such law (38 USC 4301) will prevail.
Open Enrollment

Your employer will provide an open enrollment period each year during which You may enroll Yourself and Your eligible Dependents in Southern Health without application of health status based waiting periods, exclusions, or limitations. Dependents cannot be added to Your Southern Health policy at any time other than during the open enrollment period, except as specifically outlined in the Qualifying Events Section below, or as provided in an amendment to the Group Agreement as requested by Your employer.

Eligible employees who choose not to enroll when they initially become eligible and eligible employees and Dependents who choose not to enroll within the 31 day period following any qualifying event will be excluded from enrolling in coverage under this plan for 18 months following the period in which they were eligible to enroll or until the next open enrollment period, whichever is sooner.

Dependents

This section describes Southern Health’s standard rules for Dependent eligibility. The Group Agreement describes any additional class of covered dependents along with effective dates and eligibility requirements for all Dependents. To determine the specific rules for Your group, You should contact Your group’s employee benefits office.

The following individuals, subject to the appropriate documentation, are eligible Dependents:
- Spouse;
- An unmarried child who is Your son, daughter, stepchild or legally adopted child;
- A child required to be enrolled pursuant to the terms of a Qualified Medical Child Support Order;
- A child for whom you are the legal guardian; or
- An individual that is considered part of a covered class of dependents according to the Group Agreement.

Dependents residing outside of the Service Area are subject to all coverage provisions and limitations outlined in this Evidence of Coverage.

Dependent children are eligible for coverage until the end of the period in which they reach the cut-off age specified in the employer’s Group Agreement, become employed on a full-time basis, become married, or are otherwise no longer chiefly reliant on the Subscriber for support and maintenance, whichever occurs first.

If Your group has exceptions to the cut-off age requirements for full-time students and Your Dependent child is an unmarried, full-time student in an accredited college, university, trade or secondary school who is chiefly reliant on You for support and maintenance, then he or she is eligible for continued coverage on Your policy until the end of the period in which he or she ceases to be a full-time student, marries, is no longer chiefly reliant on You for support and maintenance, or reaches the age specified in Your employer’s Group Agreement. Additionally, if a Dependent is enrolled on a Policy which has exceptions to the cut-off age for full-time students and such child is unable due to a medical condition to continue as a full-time student, coverage under the policy for such child shall continue for a period of 12 months from the date the child ceases to be a full-time student or until such child attains the cut-off age for full-time students specified in the employer’s Group Agreement/Policy, whichever occurs first, provided the child’s treating physician certifies to the insurer at the time the child withdraws as a full-time student that the child’s absence is Medically Necessary.

Southern Health must be notified when Your Dependent is no longer eligible. Southern Health may reasonably request information in order to verify Dependent status.
Disabled Dependents
Southern Health makes exceptions for coverage beyond the cut-off age specified in Your employer’s Group Agreement for Dependent children with a mental or physical disability. The Dependent must be unmarried, incapable of self-sustaining employment, and chiefly reliant on the Subscriber for support and maintenance by reason of the disability. The disabling condition must have commenced and maintained itself prior to the cut-off age specified in Your employer’s Group Agreement/Policy. Proof of the disability must be provided to Southern Health no later than 31 days after the Dependent reaches the cut-off age and upon request thereafter. The documentation will be reviewed by Southern Health to determine if the Dependent meets the above criteria. Subsequent proof of disability may be required by Southern Health but not more frequently than annually after the two-year period following the child reaching the cut-off age.

Qualifying Events that Allow Changes in Enrollment During the Plan Year

Special Enrollment Rules for Individuals Who Lose Other Coverage
Subject to the conditions set forth below, an employee and his or her dependents may enroll for coverage if the employee waived coverage under Southern Health at the time coverage was most recently made available because the employee or dependent had other coverage at the time coverage under the Southern Health plan was offered and the employee’s or dependent’s other coverage:

♦ Was COBRA continuation coverage that has since been exhausted; or,
♦ If not COBRA continuation coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term “loss of eligibility for such coverage” includes (1) a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or (2) in the case of coverage offered through an HMO, loss of coverage because the employee or dependent no longer lives or works in the HMO’s service area. This term does not include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation); or,
♦ A situation in which the employee or dependent incurs a claim that would meet or exceed a lifetime limit on all benefits offered under the other coverage.

An employee and his or her dependents may enroll for coverage if the employee’s or dependent’s Children’s Health Insurance Program (CHIP) or Medicaid coverage was terminated due to loss of eligibility or the employee or dependent becomes eligible for premium assistance subsidies.

A Dependent of an employee who is not enrolled for coverage with Southern Health may not be enrolled without the employee also enrolling.

Special Enrollment for Certain New Dependents
♦ Non-Participating Employee: An employee who is eligible but not enrolled for coverage may enroll for coverage with Southern Health upon his or her marriage, upon the birth of a child, upon a child’s adoption or placement for adoption, or pursuant to the terms of a Qualified Medical Child Support Order (even if the new Dependent does not enroll for coverage).
♦ Non-Participating Spouse: A Subscriber’s spouse may enroll at the time of marriage to the Subscriber or upon the birth, adoption, or placement for adoption of a child (even if the new Dependent does not enroll for coverage).
♦ New Dependent of Subscriber: A child who becomes a Dependent of a Subscriber as a result of marriage, birth, adoption, placement for adoption, appointment of guardianship, or change in custody may enroll at that time.
Section 8: Eligibility and Enrollment

- New Dependent of Non-Participating Employee: A child who becomes a Dependent of an employee who is eligible (but did not enroll in Southern Health) as a result of marriage, birth, adoption, or placement for adoption may enroll at that time but only if the employee enrolls at that time.

Special Rules Relating to Newborn Children
If You want Your newborn covered by Southern Health for Covered Services, You must add the newborn to Your coverage by completing an Enrollment/Change Form and submitting it to Southern Health within 31 days of the birth of Your newborn. Your Employer may deduct additional premiums.

Children of Your children (i.e. Your grandchildren) are not eligible to be added to Your Southern Health coverage.

Adopted Children/Custody Changes
Stepchildren of whom You or Your spouse have custody, as well as legally adopted children, are considered eligible for coverage if they are accepted as determined and established by Southern Health. Dependent children meeting these criteria will become eligible Dependents upon adoption, placement for adoption, permanent legal guardianship, or a change in legal custody. If adoptive or parental placement occurs within 31 days of birth, such child shall be considered a newborn child as of the date of adoptive or parental placement. The Enrollment/Change Form submitted must be accompanied by a copy of the legal documentation of the adoption, court-ordered guardianship, or custody change showing the effective date of this status change. Upon acceptance, coverage will be effective on the date of the status change.

Please note that if You wish Southern Health to consider payment of hospital or physician charges for a newborn adopted at birth, the child must be enrolled in the health plan and Southern Health must Preauthorize the inpatient stay as described in Section 3.

Court Ordered Special Enrollment for Dependents
Application for special enrollment of a Dependent child may be made at any time pursuant to the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order from a court of competent jurisdiction or a state agency stating that the employer or employee is responsible for providing coverage under Southern Health. You should contact Your employer group for answers to any questions You have with respect to a QMCSO.

In the case of court-ordered custody of a child or pursuant to a QMCSO when the employee fails to enroll the child, such child may be enrolled by a completed Enrollment/Change Form from the child’s other parent or the Department of Social Services. The effective date of a Dependent child’s coverage pursuant to a QMCSO shall be the later of (i) 31 days prior to the date Southern Health receives the Enrollment/Change Form, or (ii) the date of the QMCSO. If the employee is not enrolled in the Plan, the Employer shall enroll the employee as of the same enrollment date as the eligible Dependent and the employee shall be responsible for any required employee contributions.

Timing of Special Enrollment Request
To be eligible for Special Enrollment under this section, such Special Enrollment must be requested in writing and a completed Enrollment/Change Form must be returned to Southern Health no later than 31 days after the qualifying event, or in the case where the employee or dependent has exceeded a lifetime limit on all benefits offered under the other coverage, no later than 31 days after a claim is first denied due to the operation of a lifetime limit on all benefits.

If Southern Health is not properly notified within the 31-day period of the qualifying event, and/or if the required premiums are not paid, it may not be possible to change coverage or add Dependents for 18 months or until Your next open enrollment period, whichever is sooner.
Southern Health is not responsible for any medical expenses incurred by employees or Dependents not added within the required time frame.

Instead of having a 31-day notification period, an employee or dependent whose CHIP or Medicaid coverage is terminated due to loss of eligibility or an employee or dependent who becomes eligible for premium assistance subsidies has 60 days from the date of the qualifying event to request special enrollment by submitting a completed Enrollment/Change form.

**Effective Date of Special Enrollment**

- If Your spouse is eligible for coverage, as determined and established by Southern Health, then his/her coverage will be effective on the date of Your marriage or the first day of the following month, whichever You specify.
- For Dependent children, coverage will become effective the date of the birth, adoption, or placement of adoption, appointment of guardianship, date of custody change, or for a QMCSO as described above.
- If enrollment is due to a loss or change of other coverage, Your coverage with Southern Health will be retroactive to the date of the loss of prior coverage.
- If enrollment is due to an employee’s or dependent’s CHIP or Medicaid coverage being terminated due to loss of eligibility or the employee or dependent becoming eligible for premium assistance subsidies coverage with Southern Health will be effective the first of the month following the special enrollment request.

**Events that Require Termination of a Dependent**

**Divorce**

Southern Health must be notified in the event of a divorce. The Subscriber’s spouse will cease to be an eligible Dependent at the end of the month in which a divorce occurs. An Enrollment/Change Form, available from Your employer, must be submitted to Southern Health within 31 days of the last day of the month in which a divorce occurs so that the former spouse can be removed from the policy. **Untimely notification may result in additional premiums.** If a Subscriber remarries in the month in which a divorce occurs, only one spouse may be covered in that month.

**Death of a Spouse or Child**

Southern Health must be notified upon the death of a spouse or child. An Enrollment/Change Form must be completed and received within 31 days of death. **Untimely notification may result in additional premiums.** Your employer may deduct less premium for the change in coverage.

**Termination of Coverage**

When Your employer allows, a Subscriber may terminate coverage by notifying his/her employer. The employer will then submit the appropriate paperwork. If You leave Your employment, Your employer will submit the appropriate paperwork indicating the date Your coverage will end. Upon receipt of this employer notification, Your coverage will terminate as of the date indicated by Your employer unless this date is not in accordance with the provisions as stated in the Group Agreement and its amendments and attachments thereto.

In addition, the Southern Health coverage of a Subscriber and covered Dependents will be terminated in the event that any of the following occurs:

- If a Subscriber ceases to meet the eligibility requirements set forth in this *Evidence of Coverage*, then coverage will terminate for the Subscriber and covered Dependents at the end of the period in which eligibility ceases. If Southern Health terminates coverage for reasons
other than a Member no longer satisfies the eligibility requirements or as otherwise provided below, the Member will be given 31 days written notice of such termination. If a covered Dependent ceases to meet the eligibility requirements as set forth in this Evidence of Coverage, Southern Health must be notified promptly. Coverage for that Dependent will terminate at the end of the month in which eligibility ceased. Southern Health will not provide coverage for any medical expenses incurred while a Member was not eligible for coverage. A Subscriber or covered Dependent who ceases to meet the eligibility requirements can convert to an individual policy according to the terms stated in Section 8 of this Evidence of Coverage.

If a Subscriber or covered Dependent misuses the Member ID card issued by Southern Health or allows persons other than the one specifically named on the Member ID card to attempt to obtain Southern Health benefits, or fraudulently obtains prescriptions or medical services or devices then coverage by Southern Health will be terminated for the Subscriber and covered Dependents upon 31 days written notice from Southern Health.

If a Participating hospital, physician, or other health care provider, after Southern Health’s reasonable efforts to provide this opportunity to the Member, is unable to establish and maintain a satisfactory provider-patient relationship with a Member, Southern Health may terminate the coverage of that Member and all other family members covered on that same policy. This can be done with 31 days written notice to the Subscriber and to the employer. In the event that premiums have already been received by Southern Health for coverage for this family or individual, those premiums will be refunded and Southern Health will have no further liability or responsibility under this policy. Repeatedly seeking and receiving services that are not Medically Necessary as determined by Southern Health and the provider in question shall also be considered the inability to establish and maintain a satisfactory provider-patient relationship.

In the event the first month’s premium is not paid in full by the due date, Southern Health may void coverage back to the effective date upon written notice.

In the event that any premium after the first premium payment is not received by Southern Health within the 31-day grace period following the premium due date, then coverage may be immediately terminated after the 31st day. During the grace period, coverage shall continue in force unless Your employer has given Southern Health advance written notice of discontinuance in accordance with the Group Agreement and in advance of the date of discontinuance. Your employer may be liable to Southern Health for payment of premium amounts for the time the Group Agreement was in force during the grace period.

If a Member participates in activities that endanger the safety and welfare of Southern Health or its employees or providers, then immediate notice of termination shall be given for that Member and all other family members covered on the same policy.

If the Group’s policy between Southern Health and the group is terminated for any reason including, but not limited to, fraud or misrepresentation by the group or nonpayment of initial group premiums, a Member’s coverage under this Evidence of Coverage shall terminate the date of the group’s termination. Such group termination will only be effective after Southern Health has given the group any notice required pursuant to the Group Agreement. The group is responsible for notifying the Subscriber of the group’s policy termination. Failure of the group to notify the Subscriber of termination shall not constitute continued coverage beyond the effective date of termination of the Group. If notice of termination is provided to the Subscriber by Southern Health, it shall be deemed acceptable in lieu of notice by the group.
Section 8: Eligibility and Enrollment

A Member whose coverage terminates as a result of this provision may convert to an individual policy according to the terms stated in this Evidence of Coverage.

If a Subscriber’s coverage is terminated as described, this termination will be for the Subscriber and all covered Dependents.

Except as specifically provided in Section 8, no benefits shall be provided under this Evidence of Coverage for services rendered after the date coverage would otherwise terminate as provided herein including services rendered in connection with an injury or illness that commenced prior to the effective date of termination. Any medical expenses incurred after the effective date of the termination of coverage will be the responsibility of the Member.

Continuation of Coverage

If a You are no longer eligible for coverage under the Group Agreement/Policy, You will have one of two options. You may (1) convert to an individual policy or (2) continue present group coverage for the greater of the COBRA coverage period or a 90-day period. One of these options has been chosen by Your employer. Your benefit administrator can tell You which option Your employer has chosen.

Conversion Option

If Your employer chooses this option, You may convert to an individual policy when Your coverage terminates, provided You meet all of the following requirements:

♦ You are neither covered by nor eligible for benefits under Title XVIII of the United States Social Security Act (Medicare).
♦ You are neither covered by nor eligible for substantially the same level of hospital, medical, and surgical benefits under state or federal law such as COBRA.
♦ You have been continuously covered during the 3 month period immediately preceding that Your termination of coverage.
♦ You were not terminated by Southern Health for reasons outlined in Section 8 of this Evidence of Coverage, except in the following situation: (1) if a Subscriber or covered Dependent ceases to meet the eligibility requirements set forth in this Evidence of Coverage and is terminated, or (2) if a Member is terminated as a result of the Group Agreement termination. In either of these situations, the Subscriber and/or Dependent(s) may convert to an individual policy under the terms stated below.

Any person eligible to convert to an individual policy must contact Southern Health’s Customer Service Department. You will be sent the appropriate Enrollment/Change Form. Application for conversion must be received by Southern Health within 31 days of the date You cease to be covered through Your employer, of the date a Dependent ceases to be eligible on the policy of a parent or former spouse, or of the death of the Subscriber. If Southern Health does not receive Your application within these 31 days, You will not be eligible for the individual policy.

Only the Subscriber and those Dependents currently covered on the Subscriber’s policy through his/her employer are eligible to convert to an individual policy. Dependents who are not currently covered cannot be added to an individual policy. An eligible Dependent child may be added within 31 days, due to birth or adoption, and a spouse may be added within 31 days of marriage.

Southern Health conversion coverage benefits and premiums may be different than Your current benefits and premiums and are subject to the rules and provisions of Southern Health which are in effect at the time application for such conversion is made.
Continuation of Group Coverage for a 90 Day Period
If Your employer chooses this option, You will get the benefits described in this Certificate of Insurance for the greater of any COBRA coverage period or a 90-day period immediately following the date Your eligibility terminated.

In order to be eligible to continue group coverage for a 90-day period You must meet all of the following requirements:

- You are neither covered by nor eligible for benefits under Title XVIII of the United States Social Security Act (Medicare).
- You are neither covered by nor eligible for substantially the same level of hospital, medical, and surgical benefits under state or federal law such as COBRA.
- You have been continuously covered during the 3-month period immediately preceding that Member’s termination of coverage.
- You were not terminated for reasons outlined in Section 9 of this Certificate of Insurance, except in the following situation: (1) if a Subscriber or covered Dependent ceases to meet the eligibility requirements set forth in this Certificate of Insurance and is terminated, or (2) if a Member is terminated as a result of the Group Agreement/Policy termination.
- The application for extended coverage is made to the Group and the total premium for the 90-day period is paid to the Group prior to Your termination of coverage.

The premium for continuing the group coverage shall be at the Group’s current rate applicable to the Group Agreement/Policy.

Continuation of Group Coverage Under COBRA

- **Length of Coverage:** You are eligible to retain coverage under this Group Agreement during any continuation coverage period or federal or state election period necessary for the employer group’s compliance with the requirements of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) or the Uniform Services Employment and Re-employment Rights Act or any similar state law requiring the continuation of group benefits for Members, provided the premiums for such Members continue to be paid by the employer group pursuant to the terms of the Group Agreement/Policy and COBRA, and You are eligible for COBRA coverage.

- **Termination of Coverage:** Coverage shall automatically terminate at the end of the minimum period of time required by COBRA or other applicable federal or state law or regulation.

- **Questions About Continuation Coverage:** You should contact Your employer group for the answers to any questions You have with respect to continuation coverage. **Southern Health does not administer COBRA coverage.**

- **Conversion Coverage:** You should also refer to the paragraph on conversion for any conversion privilege You may have at the end of any period of continuation coverage.

Extension of Benefits
If Your employer terminates its Group Agreement/Policy while You are Totally Disabled, upon payment of premium, Your coverage shall remain in full force and effect until the earliest of the following events occurs:

- You are no longer Totally Disabled
- The date You become eligible for coverage by another carrier without limitation as to the disabling condition
- 180 days from the date of termination of the Group Agreement/Policy
In order for You to qualify for Extension of Benefits, Southern Health must receive within 31 days of the termination of coverage under the Group Agreement/Policy written medical documentation of the disabling condition.

Coverage under this Extension of Benefits provision will be according to the terms of the Evidence of Coverage and Group Agreement/Policy in force for You at the time the Group Agreement/Policy terminates. You will be eligible to convert to an individual policy at the end of the period of extended benefits provided You meet all requirements outlined in Section 8 of this Evidence of Coverage.
General Provisions

Claim Forms
All Southern Health Participating Providers and non-participating pharmacies that have previously notified Southern Health, by facsimile or otherwise, of their agreement to accept as payment in full reimbursement for their services at rates available to pharmacies that are Participating Providers, including any Copayment and/or Deductible consistently imposed by Southern Health, are required to file claims directly with Southern Health. If You receive a bill or statement, contact the provider to make sure the provider has Your correct Southern Health information so the provider can file directly with Southern Health.

It is Your responsibility to apply any payments made directly to You for Covered Services rendered by a Non-Participating Provider to the provider’s claim payment.

Please note that even though claims are filed directly with Southern Health, some providers send a summary of charges to the patient for his or her information.

Notice of Insurance Information Practices (Abbreviated)
The following is an abbreviated notice of Southern Health’s Insurance Information Practices.

♦ Personal information about the individual proposed for coverage may be collected from persons other than that individual
♦ Personal information, as well as other personal or privileged information subsequently collected by Southern Health, in certain circumstances, may be disclosed to third parties without Your authorization
♦ You have a right of access and correction with respect to all personal information collected
♦ Upon request, we will provide You with a complete description of Southern Health’s Insurance Information Practices, which includes:
  ♦ From whom, other than Yourself, personal information may be collected
  ♦ The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information
  ♦ To whom we will disclose information and the circumstances under which such disclosures may be made without Your prior authorization
  ♦ A description of Your rights by law to be able to access, correct, amend, or delete recorded personal information
♦ Medical and other privileged information provided to Southern Health is kept confidential and will be used only for administration of Southern Health benefits or for coordinating benefits with other plans. You may contact the Customer Service Department for further information.

Coordination of Benefits
This coordination of benefits (COB) provision applies when You have health care coverage under more than one plan. The term “Plan” as it applies to this Section is defined below. The order of benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the Plan that pays first without regard to the possibility that another Plan may cover some expenses. The Secondary Plan pays after the Primary Plan or other applicable group
health insurance has paid according to its contract so that payments from all group Plans do not exceed 100% of the total after reimbursement of Allowable Expense.

**Definitions Relating to the COB Provisions**

For the purposes of this Section, the following definitions apply:

A “Plan” is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts. “Plan” includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or self-insured), including student health insurance; hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group contracts; and Medicare or other governmental benefits, as permitted by law and subject to the rules on COB with Medicare set forth below. “Plan” does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage; benefits for nonmedical components of group long-term care policies; medical benefits under group or individual automobile contracts; Medicare supplement policies; Medicaid policies; and coverage under other governmental Plans, unless permitted by law. Each contract for coverage is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

The order of benefit determination rules determine whether Southern Health is a “Primary” Plan or “Secondary” Plan when compared to another Plan covering You or Your Dependent. When Southern Health is Primary, Our benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When Southern Health is Secondary, Our benefits are determined after those of another Plan and will be coordinated with the Primary Plan’s benefits. Southern Health does not coordinate benefits for pharmacy. That is, when a member has other prescription drug coverage and that coverage is Primary, Southern Health will not pay any benefits as Secondary.

“Allowable Expense” means a health care service or expense, including deductibles and copayments, that is covered, at least in part by any of the Plans covering You or Your Covered Dependent. When a Plan provides benefits in the form of service, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

- If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient’s stay in a private hospital room is otherwise a covered benefit) is not an Allowable Expense.
- If a Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangements shall be the Allowable Expense for all Plans.
- The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

“Claim Determination Period” means a Benefit Year. However, it does not include any part of a year before the date this COB provision or a similar provision takes effect.
“Closed Panel Plan” is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

“Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Coordination of Benefits with Medicare for Members under 65 with a Disability or ESRD

Which Plan pays First? Order of Benefit Determination Rules

<table>
<thead>
<tr>
<th>When a Member is covered by 2 group plans, and</th>
<th>Then</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>If one plan does not contain a COB provision</td>
<td>The plan without COB provision is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan with COB provision is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is the subscriber under one plan and dependent under the other</td>
<td>The plan covering the Member as the subscriber is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan covering the person as a dependent is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is the subscriber under a retiree plan and dependent under an active plan</td>
<td>The plan covering the Member as the subscriber is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan covering the person as a dependent is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is a subscriber in two active group plans</td>
<td>The plan that has been in effect longer is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan that has been in effect the shorter amount of time is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is a subscriber under both an active employee plan and a retiree plan</td>
<td>The plan which the subscriber is an active employee is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The retiree plan is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is an active employee on one plan and enrolled as a COBRA subscriber</td>
<td>The plan which the subscriber is an active employee is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The COBRA plan is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is covered as a dependent child under both plans</td>
<td>The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>NOTE: If the parents have the same birthday (MM/DD), the plan that has been in effect longer is</td>
<td>The plan of the parent whose birthday is later in the calendar year is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>The Group Plan is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is covered as a dependent child and coverage is specified in a court decree</td>
<td>The plan of the parent primarily responsible for health coverage under the court decree is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan of the other parent is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is covered as a dependent child and coverage is not specified in a court decree</td>
<td>The custodial parent or spouse of custodial parent’s plan is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The non-custodial parent’s plan is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The Member is covered as a dependent child and the parents share joint custody</td>
<td>The plan of the parent whose birthday occurs earlier in the calendar year is</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>NOTE: If the parents have the same birthday (MM/DD), the plan that has been in effect longer is</td>
<td>The plan of the parent whose birthday is later in the calendar year is</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>When a Member is covered by Medicare and a group plan, and</td>
<td>Then</td>
<td>Southern Health is Primary</td>
<td>Medicare is Primary*</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------</td>
<td>---------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Is a Member who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD)</td>
<td>For the first 30-months after Medicare becomes effective</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Upon completion of the 30-months after Medicare becomes effective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is a disabled Subscriber who is an active employee</td>
<td>If the employer employs 100 employees or more</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the employer employs fewer than 100 employees</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Is the disabled spouse or dependent child of an active full-time Subscriber</td>
<td>If the employer employs 100 employees or more</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the employer employs fewer than 100 employees</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to disability</td>
<td>If Medicare had been secondary to the group plan before ESRD entitlement, then for the first 30 months following ESRD entitlement</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If Medicare had been primary to the group plan before ESRD entitlement</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Disabled and Subscriber not actively employed by the employer group</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When a Member is covered by Medicare and a group plan, and</th>
<th>Then</th>
<th>Southern Health Primary</th>
<th>Medicare is Primary*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The member is age 65 or over, and is the Subscriber or the Subscriber’s spouse, and the Subscriber is actively working for employer group</td>
<td>If the employer group has less than 20 employees</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the employer group has 20 or more employees</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to age.</td>
<td>If Medicare had been secondary to the group plan before ESRD entitlement, then for the first 30 months following ESRD entitlement</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If Medicare had been primary to the group plan before ESRD entitlement</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>The member is age 65 or over, is the Subscriber or the Subscriber’s spouse and the Subscriber is not actively working for the group</td>
<td></td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>
Coordination of Benefits with Medicare

The preceding charts show You when Medicare is Primary and when it is Secondary. If You are eligible for Medicare as Your Primary coverage, You must still obtain any necessary Preauthorizations for those services to be eligible for coverage.

If You are eligible for Medicare as Your Primary coverage and You do not elect Medicare Part B coverage, Southern Health will process Your claims as if You had Medicare Part B coverage, and will coordinate the amount it pays with the amount of the Medicare Part B coverage had it existed.

Medicare Carve-out

For groups that have a Medicare Carve-out premium, Subscribers and/or their Dependents who are retirees, spouses of retirees, or anyone for whom Medicare would be primary if the person were enrolled and eligible for Medicare Parts A and B, must accept and be covered by both Parts A and B of Medicare in order to obtain the carve-out premium offered by Southern Health. Upon obtaining Parts A and B, the Member must notify Southern Health within 31 days in order to be eligible for the carve-out rate. We will not make retroactive changes to the carve-out rate. The Member is responsible for notifying Southern Health immediately in the event the Subscriber or Dependent either loses Medicare coverage or discontinues Part B. As a result of such status change or discontinuance of Medicare Part B coverage, the Member will no longer be eligible for the carve-out premium. Additionally, Southern Health may retroactively adjust the premium rate accordingly back to the effective date of the change. You should verify with Your employer whether or not You have a carve-out rate.

ALS (Lou Gehrig’s Disease)

As of July 1, 2001, the waiting period to qualify for Medicare benefits for persons on Social Security Disability with a diagnosis of ALS has been waived.

NOTE: Usually, once a person is approved for Social Security Disability, there is a two-year waiting period until the person is eligible to enroll in Medicare. This legislative change waives that waiting period but the Member must still be approved for Social Security Disability under the appropriate diagnosis code. Individuals must state on their disability application form that they have ALS.

This is not similar to ESRD entitlement where the law requires that the employer group health plan is the primary payer for a period of time. With ALS, Medicare is primary (subject to Medicare Secondary Payer laws regarding persons covered by virtue of active employment with a large employer group health plan) immediately upon enrollment in the federal Medicare Program.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

♦ Provide Southern Health with Information about other coverage and promptly notify Southern Health of any coverage changes
♦ Promptly respond to any requests for information from Southern Health
♦ Give Southern Health the right to obtain information as needed from others to coordinate benefits
♦ Return any excess amounts to Southern Health if we make a payment and later find that the other Coverage should have been primary
Out-of-Network Benefits

Your Southern Health POS Plan offers You the option to receive services from a Participating Southern Health Provider or Non-Participating Provider. When You choose to receive services from a provider who does not participate with the Southern Health Plan this is called Your “Out-of-Network Benefit.” Under Your Out-of-Network Benefit, You have access to all of the Covered Services described in Section 6 of this Evidence of Coverage. The Copayment, Coinsurance, Deductible and any Benefit Maximum listed on Your Schedule of Benefits for Out-of-Network services will apply.

When You receive care from a Non-Participating Provider You are responsible for all administrative aspects of the plan described in this Evidence of Coverage such as claims filing, notification of emergent inpatient admissions, and Preauthorization. These procedures are described in more detail below. In addition, please be aware that You may be balance billed by the Non-Participating Provider as described in this Section.

Balance Billing

Southern Health’s payment for services is based on an Allowable Charge. When services are received from a Participating Provider who has agreed to Southern Health’s negotiated rate Members are not responsible for the difference between the negotiated rate and the billed amount. This amount is “written off” by the Participating Provider. For Out-of-Network Covered Services, the benefit payable is based on the Allowable Charge that Southern Health has determined to be applicable to Non-Participating Providers. Southern Health’s Allowable Charge for Non-Participating Providers is 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 Virginia St. Anthony’s fee schedule, or a fixed percentage of billed charges. The type and place of service determines the applicable schedule/rate. Southern Health's Allowable Charge policy provides further details on the determination/calculation of Out-of-Network Rates.

When the Non-Participating Provider bills You for the amounts over and above the Southern Health Allowable Charge, this is called “balance billing.” You are responsible for all amounts above the Allowable Charge in addition to any Copayment, Coinsurance, Deductible, or Penalty required for the services received. Section 4, “What You Pay,” contains a chart of the differences between coverage in and out of the Southern Health Network. Any amounts billed over the Allowable Charge do not accumulate towards Your Benefit Year maximum out-of-pocket.

Claims filing

If You receive care from a Non-Participating Provider, this provider is not under contract with Southern Health and is not required to follow our standard claim filing procedures. The Non-Participating Provider may give You copies of statements or a claim form to file with Southern Health. It is Your responsibility to ensure that the claim is filed with Southern Health. You may file the claim by using the health claim form that was included with Your membership materials. The form must be completed in its entirety and sent to Southern Health, Claims Department, P.O. Box 7704, London, Kentucky 40742. Be sure to indicate whether payment should be made to the provider or directly to You. Claims for services from Non-Participating Providers must be received by Southern Health within one year from the date of service in order to be considered for payment. Incomplete claim forms will be returned to You.
For services received outside the United States Southern Health will process all claims for Covered Services when there is a fully-itemized bill translated into English that includes the patient’s name, ID number, date of service, cost of the service in US dollars, and the diagnosis for the condition. All claims information and explanations submitted to Southern Health must be in writing and received within one year from the date on which the service was rendered. Depending on the provider’s business policies, the member may be required to file claims for reimbursement.

**Preauthorization**

If You are being treated by a non-participating physician and You need services that require Preauthorization, then either You or Your physician can call Southern Health to obtain Preauthorization. The number for Preauthorization is (804) 270-9200 or, if outside the Richmond dialing area, (800) 235-2206. The Preauthorization nurse will need to know what type of procedure You are having as well as the date, facility, and admitting physician. If the nurse needs more information in order to verify Medical Necessity, then Your physician may be contacted. After admission to the hospital in an emergency, Preauthorization will be required once You are considered clinically stable in order to continue receiving services from a Non-Participating Provider at the In-Network level of benefits.

**Traveling**

Members who are traveling outside of the Southern Health Service Area, whether out of state or out of the country, are covered for routine services according to the provisions of Section 6, Covered Benefits. If You have a non-emergent medical need while traveling, please contact Southern Health’s Customer Service Department for specific Preauthorization and coverage conditions.

Coverage for emergencies outside the country are covered according to the Emergency Benefits paragraph in Section 6, Covered Benefits. When accessing services outside the service area, present Your Southern Health Member ID card to the medical providers and ask that they file the charges directly with Southern Health. In some cases, You may be asked to pay for emergency or acute illness care. If this occurs, simply submit an itemized statement to Southern Health for review. Reimbursement from this statement will be made to the Subscriber or directly to the provider for all Covered Services, less Your payment responsibility. Be sure to include Your name, Member number, and a brief explanation of the circumstances surrounding the emergency or acute illness.
Service Area

**Virginia Counties**

<table>
<thead>
<tr>
<th>County</th>
<th>County</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albemarle</td>
<td>Franklin</td>
<td>Nottoway</td>
</tr>
<tr>
<td>Alleghany</td>
<td>Frederick</td>
<td>Orange</td>
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<tr>
<td>Amelia</td>
<td>Giles</td>
<td>Page</td>
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<tr>
<td>Amherst</td>
<td>Goochland</td>
<td>Patrick</td>
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<tr>
<td>Appomattox</td>
<td>Grayson</td>
<td>Pittsylvania</td>
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<td>Arlington</td>
<td>Greene</td>
<td>Powhatan</td>
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<tr>
<td>Augusta</td>
<td>Greensville</td>
<td>Prince Edward</td>
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<tr>
<td>Bath</td>
<td>Halifax</td>
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<td>Bedford</td>
<td>Hanover</td>
<td>Prince William</td>
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**Virginia Cities**

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**West Virginia Counties**

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*West Virginia counties only for services rendered to Members in those counties. No groups located in these counties.*