This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://resources.hewitt.com/southernco or by calling 1-888-435-7563.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person/**$750** family in network and **$500** person/**$1,500** family out-of network for medical, mental health &substance abuse. Not applicable to preventive care, physician, inpatient, drugs, non-covered or balance-billed charges.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** per person for in-network retail prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before the plan begins to pay for these services
Is there an out–of–pocket limit on my expenses?	Yes.**$1,500** person/**$4,500** family in-network and **$3,000** person/**$9,000** family out-of-ntwk for medical, mental health & substance abuse. In-ntwk.pharmacy:**$5,650**person/**$9,800**family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for non-compliance, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.anthem.com or call 1-877-271-2904	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

Questions: Call **1-877-271-2904** or visit us at **www.anthem.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.dol.gov/ebsa/pdf/SBCUniform Glossary.pdf** or call **1-877-271-2904** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	40% coinsurance	————————none————————
	Specialist visit	$25 copay	40% coinsurance	————————none————————
	Other practitioner office visit	20% coinsurance for chiropractor	20% coinsurance for chiropractor	Chiropractic care limited to 25 visits per year for in and out-of-network combined.
	Preventive care/screening/immunization	No charge	No charge	Please see plan documents for a list of preventive services or call 1-877-271-2904
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	No Charge	40% coinsurance	Precertification is required

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or **1-800-843-5670**	Generic drugs	Up to 31-day supply: 10% coinsurance after $50 deductible Up to 90-day supply: $10 copay; no deductible	Not Covered	$5 min. charge or actual cost (whichever is lower) at retail. FDA approved contraceptives covered at no charge. 90-day supply only if purchased through CVS Caremark Mail Service or a CVS Pharmacy; otherwise you pay 2x coinsurance (or copay) after grace period.
	Preferred brand drugs	Up to 31-day supply: 20% coinsurance after $50 deductible Up to 90-day supply: $30 copay; no deductible	Not Covered	$5 min. charge or actual cost (whichever is lower) at retail. If generic is available, coinsurance includes the difference in cost between the brand name and generic. 90-day supply only if purchased through CVS Caremark Mail Service or a CVS Pharmacy; otherwise you pay 2x coinsurance after grace period.
	Non-preferred brand drugs	Up to 31-day supply: 30% coinsurance after $50 deductible Up to 90-day supply: $60 copay; no deductible	Not Covered	$5 min. charge or actual cost (whichever is lower) at retail. If generic is available, coinsurance includes the difference in cost between the brand name and generic. 90-day supply only if purchased through CVS Caremark Mail Service or a CVS Pharmacy; otherwise you pay 2x coinsurance after grace period.
	Specialty drugs	Standard coinsurance or copays apply	Not Covered	Contact Caremark Specialty Pharmacy at 1-800-237-2767 for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay	40% coinsurance	Subject to overall deductible for out-of-network
	Physician/surgeon fees	No charge	40% coinsurance	Subject to overall deductible for out-of-network
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay	Copay waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to in-network deductible for in and out-of-network

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Urgent care	$25 copay	40% coinsurance	Subject to overall deductible for out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 initial copay per admission; $50 copay per day (days 2 – 6)	40% coinsurance	A maximum copay of $450 per admission applies. Precertification is required
	Physician/surgeon fee	No charge	40% coinsurance	Subject to overall deductible for out-of-network
If you have mental health, behavioral health, or substance abuse needs For more information about **Mental/Behavioral Health and Substance Abuse Disorder** and the **Employee Assistance Program (EAP)**, contact **Beacon Health Options** at: **1-800-680-6333**	Mental/Behavioral health outpatient services	$25 copay	40% coinsurance	Copay applies to mental health office visits only. EAP: Up to 6 in-network counseling sessions per episode, at no cost. Precert is required.
	Mental/Behavioral health inpatient services	$200 initial copay; $50 copay/day (days 2 – 6)	40% coinsurance	Program requirements apply.
	Substance abuse disorder outpatient services	$25 copay	40% coinsurance	Copay applies to mental health office visits only. EAP: Up to 6 in-network counseling sessions per episode, at no cost. Precert is required
	Substance abuse disorder inpatient services	$200 initial copay; $50 copay/day (days 2 – 6)	40% coinsurance	Program requirements apply.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$25 copay/initial visit only	40% coinsurance	————————none————————
	Delivery and all inpatient services	$200 initial copay per admission; $50 copay per day (days 2 – 6)	40% coinsurance	A maximum copay of $450 per admission applies. Precertification is required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limited to 100 visits per year. Requires Precertification, or benefit is reduced.
	Rehabilitation services	20% coinsurance	20% coinsurance	Coverage includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	20% coinsurance	Out-of-ntwk services subject to $250 in-ntwk deductible
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 120 days per calendar year for in and out-of-network combined. Out-of-network services subject to in network deductible. Precertification is required.
	Durable medical equipment	20% coinsurance	20% coinsurance	Out-of-network charges subject to $250 in-network deductible. Speech devices not covered. (See your plan document for other excluded services.)
	Hospice service	No charge	No charge	————————none————————
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Limited to one routine vision exam annually
	Glasses	Not Covered	Not Covered	————————none————————
	Dental check-up	No Charge	No Charge	Limited to screening only

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (exception for child screening)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (Requires pre-authorization and pre-certification)
- Chiropractic care
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (See your plan document for coverage criteria)
- Routine eye care (limitations apply)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-877-271-2904. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan administrator at the 1-877-271-2904. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Spanish: (Español): Para obtener asistencia en Español, llame al 1-888-435-7563.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,115
- **Patient pays** $425

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$275
Coinsurance	$0
Limits or exclusions	$150
Total	**$425**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,280
- **Patient pays** $1,120

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$250
Coinsurance	$490
Limits or exclusions	$80
Total	**$1,120**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.