**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage or to get a copy of the complete terms of coverage, http://digital.alight.com/southernco or call **1-888-435-7563**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-888-435-7563** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$250**/person, **$750**/family<br>Out-of-Network: **$500**/person, **$1,500**/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive services, physician services, inpatient services and prescription drugs. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at **www.healthcare.gov/coverage/preventive-care-benefits**. |
| **Are there other deductibles for specific services?** | Yes. In-Network Prescription Drugs: **$50**/person. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: **$2,000**/person, **$6,000**/family<br>Out-of-Network: **$4,000**/person, **$12,000**/family<br>Pharmacy (In-Network): **$5,150**/person, **$8,300**/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, health care this plan doesn't cover and precertification penalties. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of in-network providers, visit **www.CredenceBlue.com** or call **1-800-232-3973**. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | In-Network | Out-of-Network | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay per visit, no deductible | 30% coinsurance after deductible | ——————none—————— |
| | Specialist visit | $50 copay per visit, no deductible | 30% coinsurance after deductible | ——————none—————— |
| | Preventive care/screening/immunization | No charge | No charge | Additional services may be available; visit **www.CredenceBlue.com/preventiveservices**. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 30% coinsurance after deductible | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance after deductible | 30% coinsurance after deductible | Precertification required; see SPD for more information on precertification. |
| **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:** $5 copay, no deductible **Up to 90-Day Supply:** $10 copay, no deductible **FDA-Approved Contraceptives:** No charge | Not covered | 90-day supply only available if purchased through CVS Caremark Mail Service or a CVS Pharmacy; otherwise you pay 2 x copay/coinsurance. |
| | Preferred brand drugs | **Up to 31-Day Supply:** 20% coinsurance after $50 deductible ($80 max.) **Up to 90-Day Supply:** 20% coinsurance, no deductible ($200 max.) | Not covered | If generic available, coinsurance includes the difference in cost between generic and brand. 90-day supply only available if purchased through CVS Caremark Mail Service or a CVS Pharmacy; otherwise you pay 2 x copay/coinsurance. |
| | Non-preferred brand drugs | **Up to 31-Day Supply:** 30% coinsurance after $50 deductible ($100 max.) **Up to 90-Day Supply:** 30% coinsurance, no deductible ($250 max.) | Not covered | |
| | Specialty drugs | Standard coinsurance/copay applies | Not covered | Contact Caremark Specialty Pharmacy at **1-800-237-2767** for more information. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | In-Network | Out-of-Network | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Physician/surgeon fees | 10% coinsurance after deductible | 30% coinsurance after deductible | Surgery performed during an office visit may be subject to office visit copay. |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance after deductible **Non-Emergency:** 10% coinsurance after deductible and $100 facility copay per visit | 10% coinsurance after deductible **Non-Emergency:** 30% coinsurance after deductible and $100 facility copay per visit | ——————none—————— |
| | Emergency medical transportation | 10% coinsurance, no deductible | 10% coinsurance, no deductible | ——————none—————— |
| | Urgent care | Coverage is based on place of service, service rendered and contracted status of the provider | 30% coinsurance after deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance after deductible | 30% coinsurance after deductible | Precertification required; see SPD for more information on precertification. |
| | Physician/surgeon fee | 10% coinsurance after deductible | 30% coinsurance after deductible | Precertification required; see SPD for more information on precertification. |
| **If you need mental health, behavioral health or substance abuse services** | Outpatient services | $25 copay per visit, no deductible | $25 copay per visit, no deductible | Precertification required; see SPD for more information on precertification. Copay applies to office visits only. One preventive mental health visit is covered at no charge each year. |
| | Inpatient services | 10% coinsurance after deductible | 10% coinsurance after deductible | Certain limitations apply; see your SPD for more information. |
| **If you are pregnant** | Office visits | $25 copay per initial visit | 30% coinsurance after deductible | ——————none—————— |
| | Childbirth/delivery professional services | 10% coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Childbirth/delivery facility services | 10% coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | In-Network | Out-of-Network | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance after deductible | 30% coinsurance after deductible | Precertification required; see SPD for more information on precertification. Benefits are also available for home infusion services. Limited to 100 visits per year. |
| | Rehabilitation services | 10% coinsurance after deductible | 30% coinsurance after deductible | Benefits listed are for physical, occupational and speech therapy. |
| | Habilitation services | 10% coinsurance after deductible | 30% coinsurance after deductible | Benefits listed are for physical, occupational and speech therapy. |
| | Skilled nursing care | 10% coinsurance after deductible | 30% coinsurance after deductible | Limited to 120 days per calendar year. Facility must be a Medicare-approved skilled nursing facility. Precertification required; see SPD for more information on precertification. |
| | Durable medical equipment | 10% coinsurance after deductible | 30% coinsurance after deductible | Speech devices not covered. See SPD for other excluded services. |
| | Hospice services | 10% coinsurance after deductible | 30% coinsurance after deductible | Precertification required; see SPD for more information on precertification. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Limited to one routine exam each calendar year for members younger than age 18. |
| | Children's glasses | Not covered | Not covered | ——————none—————— |
| | Children's dental check-up | No charge | No charge | Limited to screening only. |

## Excluded Services and Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery (precertification required)
- Chiropractic care (limited to 25 visits/person/year)
- Infertility treatment (Progyny network only; limitations apply)
- Non-emergency care when traveling outside the U.S. (most coverage provided outside the U.S.)
- Private-duty nursing (see SPD for coverage criteria)
- Routine eye care (Adult) (limitations apply)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or **www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act** you may contact the plan at **1-888-435-7563**. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit **www.HealthCare.gov** or call **1-800-318-2596**.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: the plan at the phone number listed in your benefit booklet.

**Does this plan provide Minimum Essential Coverage?** **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al **1-888-435-7563**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-435-7563**.
Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **1-888-435-7563**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-435-7563**.

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $250 |
| Copayments | $10 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,420** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$620** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $250 |
| Copayments | $200 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$650** |

The plan would be responsible for the other costs of these EXAMPLE covered services.