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: Individual-**$1,600**, Family-**$3,200** Out-of-Network: Individual-**$4,000**, Family-**$8,000**	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive services.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual-**$3,200**, Family-**$6,400** Out-of-Network: Individual-**$8,000**, Family-**$16,000**	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, the overall family out-of-pocket limit must be 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	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Specialist visit	20% coinsurance after deductible	50% 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)	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% 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:** $10 copay after deductible **Up to 90-Day Supply:** $25 copay after deductible	Not covered	Participating pharmacy or Maintenance Choice Program only; out-of-network pharmacies are not covered. Deductible combined with medical deductible.
	Preferred brand drugs	25% coinsurance after deductible **31-Day Supply:** $25 minimum/$50 maximum; **90-Day Supply:** $62 minimum/$125 maximum	Not covered	
	Non-preferred brand drugs	40% coinsurance after deductible **31-Day Supply:** $40 minimum/$75 maximum; **90-Day Supply:** $100 minimum/$188 maximum	Not covered	
	Specialty drugs	**Up to 31-Day Supply:** $100 copay after deductible **Up to 90-Day Supply:** $200 copay after deductible	Not covered	Contact Caremark Specialty Pharmacy at **1-800-237-2767**.

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)	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	**True Emergency:** 20% coinsurance after deductible **Non-Emergency:** 50% coinsurance after deductible	——————none——————
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	——————none——————
	Urgent care	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Precertification required; see SPD for more information on precertification.
	Physician/surgeon fee	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance after deductible	20% coinsurance after deductible	Precertification required; see SPD for more information on precertification. One preventive mental health visit is covered at no charge each year.
	Inpatient services	20% coinsurance after deductible	20% coinsurance after deductible	Certain limitations apply; see your SPD for more information.
If you are pregnant	Office visits	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	Precertification required; see SPD for more information on precertification.

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	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 100 visits per calendar year. Benefits are also available for home infusion services. Precertification required; see SPD for more information on precertification.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 120 days per year, combined with medical rehabilitation. Facility must be a Medicare-approved skilled nursing facility. Precertification required; see SPD for more information on precertification.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Speech devices not covered (see SPD for other excluded services).
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If your child needs dental or eye care	Children's eye exam	20% coinsurance after deductible	50% coinsurance after deductible	Limited to one routine exam each calendar year.
	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 (only for morbid obesity in limited circumstances) • Chiropractic care (limited to 25 visits/member/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	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
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	$1,600
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

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

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
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	$1,600
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
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	$1,600
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,810**

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