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, visit 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 https://www.healthcare.gov/sbc-glossary/ or call 1-877-320-7504 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	You don't have to meet deductibles for specific services but see the Common Medical Events chart below for other costs for services this plan covers.
Are there other deductibles for specific services?	Yes. $50 per person for 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 this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$1,500 individual/$4,500 family for in-network medical, and in and out-of-network mental health, and substance abuse services. For prescription drug coverage: $5,650 individual/$9,800 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, and health care this plan doesn't cover.	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. See www.myvivaprovider.com or call 1-800-294-7780 for a list of network providers.	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, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	MD Live telehealth service: $15 copay per consultation.
	Specialist visit	$25 copay/visit	Not covered	----------none----------
	Preventive care/screening/ immunization	No charge	Not covered	Limited to services recommended by federal preventive guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Office visit copay may apply. Precertification required for genetic testing; if not obtained, no charges for those services will be covered by the plan.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://digital.alight.com/southernco	Generic drugs	Up to 31-Day Supply: If the full cost is $5 or less: member pays the full cost; If the full cost is greater than $5: member pays the greater of $5 or 10% coinsurance. Up to 90-Day Supply: $10 copay at CVS Pharmacy or CVS Caremark Mail Service.	Not covered	Coinsurance doubled after first 3 fills if maintenance drugs not filled as a 90-day supply. No charge for FDA-approved contraceptives.

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs	Up to 31-Day Supply: If the full cost is $5 or less: member pays the full cost; If the full cost is greater than $5: member pays the greater of $5 or 20% coinsurance. Up to 90-Day Supply: $30 copay at CVS Pharmacy or CVS Caremark Mail Service.	Not covered	If generic alternative available, pay difference between generic and brand name. Coinsurance doubled after first 3 fills if maintenance drugs not filled as 90-day supply.
	Non-preferred brand drugs	Up to 31-Day Supply: If the full cost is $5 or less: member pays the full cost; If the full cost is greater than $5: member pays the greater of $5 or 30% coinsurance. Up to 90-Day Supply: $60 copay at CVS Pharmacy or CVS Caremark Mail Service.	Not covered	If generic alternative available, pay difference between generic and brand name. Coinsurance doubled after first 3 fills if maintenance drugs not filled as 90-day supply.
	Specialty drugs	Generic: $10 copay; Preferred Brand: $30 copay; Non-Preferred Brand: $60 copay	Not covered	Subject to special requirements and prior authorization for plan to pay for Specialty drugs. 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/service	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Physician/surgeon fees	No charge	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan.

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$50 copay/visit	$50 copay/visit	Limited to emergency medical conditions. Copay waived if admitted to hospital. Follow-up care not covered. See plan documents for more information.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to transportation to a hospital.
	Urgent care	$25 copay/visit	$25 copay/visit	Coverage from out-of-network providers is limited to care outside the VIVA HEALTH service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/admission	Not covered except for emergency medical conditions	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Physician/surgeon fees	No charge	Not covered except for emergency medical conditions	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Inpatient services	$100 copay/admission.	$100 copay/admission.	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you are pregnant	Office visits	$25 copay/delivery	Not covered	No coverage for surrogate pregnancy. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC. See plan documents for more information.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$350 copay/admission	Not covered	
If you need help recovering or have	Home health care	20% coinsurance	Not covered	Limited to 100 visits per person per calendar year. Requires prior authorization for plan to pay

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs				for care. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Rehabilitation services	20% coinsurance	Not covered	Includes physical, speech, and occupational therapy. Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Habilitation services	20% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to diagnosis of autism, autism spectrum disorder, or pervasive developmental delay.
	Skilled nursing care	20% coinsurance	Not covered	Limited to 120 days per person per calendar year. Requires prior authorization for plan to pay for care. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Durable medical equipment	20% coinsurance	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Hospice services	No charge	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one in-network routine visit/year; other medically necessary visits for illness or injury: $25 copay/visit.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	No charge	Not covered	Limited to in-network screenings only.

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

Excluded Services & 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 (except reconstructive surgery necessary to repair a functional disorder from disease, injury or congenital anomaly)
- Dental care (adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Bariatric surgery
- Chiropractic care (limited to 25 visits/year)
- Infertility treatment (Progyny network only; limitations apply)
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (diabetics only)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: VIVA HEALTH at 1-800-294-7780 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-877-320-7504.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-320-7504.

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

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

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	$0
Specialist copay	$25
Hospital (facility) copay	$350
Other cost sharing	none

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$10
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$470**

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

The plan's overall deductible	$0
Specialist copay	$25
Hospital (facility) copay	$350
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$470**

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

The plan's overall deductible	$0
Specialist copay	$25
Hospital (facility) copay	$350
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$10
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$510**

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