


## 14CY1000 - RxPHS

 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, call 1- 866-403-2785 or visit [www.alliantplans.com](http://www.alliantplans.com). 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](http://www.healthcare.gov) or call 1- 866-403-2785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In Network: \$1,000/Individual, \$3,000/Family Out of Network: \$3,000/Individual, \$9,000/Family	You must pay all the costs up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for covered services you use. Check your policy or <a href="#">plan</a> document to see when the <a href="#">deductible</a> 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 <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care/screening</a> /immunization. Additional details included per service category elsewhere in this SBC.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet a <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In Network: \$1,000/Individual, \$3,000/Family Out of Network: \$6,000/Individual, \$18,000/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges (unless balance billing is prohibited), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.alliantplans.com">www.alliantplans.com</a> or call 1-800-811- 4793 for a list of <a href="#">network providers</a> .	This plan uses a <a href="#">provider network</a> . <a href="#">You will pay less if you use a provider</a> , in the plan's network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> , for the difference between the <a href="#">provider's</a> charge and what your plan pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> , before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness.	\$25 copayment, deductible does not apply	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Specialist</a> visit	\$50 copayment, deductible does not apply	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Preventive care/screening</a> /immunization	No Charge	40% coinsurance after deductible	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.alliantplans.com">www.alliantplans.com</a>	Generic drugs	\$15 copayment, deductible does not apply	\$15 copayment, deductible does not apply	See your plan's Certificate of Coverage for details
	Preferred brand drugs	\$40 copayment, deductible does not apply	\$40 copayment, deductible does not apply	
	Non-preferred brand drugs	\$70 copayment, deductible does not apply	\$70 copayment, deductible does not apply	
	<a href="#">Specialty drugs</a>	25% coinsurance, up to \$400 maximum per Rx, deductible does not apply	25% coinsurance, up to \$400 maximum per Rx, deductible does not apply	

\* For more information about limitations and exceptions, see your plan's CERTIFICATE OF COVERAGE

<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Physician/surgeon fees	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 copayment, deductible does not apply	\$250 copayment, deductible does not apply	See your plan's Certificate of Coverage for details
	<a href="#">Emergency medical transportation</a>	0% coinsurance after deductible	0% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Urgent care</a>	\$75 copayment, deductible does not apply	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details.
	Physician/surgeon fees	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 copayment, deductible does not apply	40% coinsurance after deductible	Other Outpatient services may include intensive outpatient therapy (IOP), partial hospitalization program (PHP), tests described elsewhere in the SBC.
	Inpatient services	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details.

If you are pregnant	Office visits	\$25 copayment, deductible does not apply	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Childbirth/delivery professional services	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Childbirth/delivery facility services	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Rehabilitation services</a>	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Habilitation services</a>	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Skilled nursing care</a>	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Durable medical equipment</a>	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	<a href="#">Hospice services</a>	0% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"><li>• Abortion (except in case of rape, incest, or when life of mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li></ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan document</u>.)</b>		
<ul style="list-style-type: none"><li>• Cosmetic surgery limited to reconstructive surgery to restore function</li></ul>	<ul style="list-style-type: none"><li>• Weight loss programs (4 visits per year for nutritional counseling)</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care - Limited to 20 visits</li></ul>

**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: Alliant Health Plans at 1- 866-403-2785 , the Georgia Department of Insurance, 1-800-656-2298 or [www.oci.ga.gov](http://www.oci.ga.gov), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](http://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](#). The contact information for questions about your rights, this notice, or assistance: Alliant Health Plans at 1- 866-403-2785 , the Georgia Department of Insurance , 1-800-656-2298 or [www.oci.ga.gov](http://www.oci.ga.gov), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [minimum essential coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-833-613-2262.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-613-2262.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-613-2262.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-613-2262.

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

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50	■ <a href="#">Specialist copayment</a>	\$50	■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	\$0	■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other	Not Applicable	■ Other	Not Applicable	■ Other	Not Applicable

**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*)

**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*)

**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		\$12,700	Total Example Cost		\$5,600	Total Example Cost		\$2,800
<b>In this example, Peg would pay:</b>			<b>In this example, Joe would pay:</b>			<b>In this example, Mia would pay:</b>		
<i>Cost Sharing</i>			<i>Cost Sharing</i>			<i>Cost Sharing</i>		
<a href="#">Deductibles</a>	\$1,000	<a href="#">Deductibles</a>	\$500	<a href="#">Deductibles</a>	\$900	<a href="#">Deductibles</a>	\$900	
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$500	<a href="#">Copayments</a>	\$60	<a href="#">Copayments</a>	\$60	
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	
<i>What isn't covered</i>			<i>What isn't covered</i>			<i>What isn't covered</i>		
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0	Limits or exclusions	\$0	
<b>The total Peg would pay is</b>	<b>\$1,060</b>	<b>The total Joe would pay is</b>	<b>\$1,020</b>	<b>The total Mia would pay is</b>	<b>\$960</b>			

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: