


## 14CY1001 - Rx25

 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<br>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: \$4,000/Individual, \$12,000/Family<br>Out of Network: \$12,000/Individual, \$36,000/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)     | 20% coinsurance after deductible                                       | 40% coinsurance after deductible                                       | See your plan's Certificate of Coverage for details   |
|  | Imaging (CT/PET scans, MRIs)                            | 20% 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<br>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)   | 20% coinsurance after deductible           | 40% coinsurance after deductible           | See your plan's Certificate of Coverage for details  |
|--|--|--|--|--|
|  | Physician/surgeon fees                           | 20% 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<br>(You will pay the least)     | Out of Network<br>(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> | 20% coinsurance after deductible           | 20% 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)               | 20% coinsurance after deductible           | 40% coinsurance after deductible           | See your plan's Certificate of Coverage for details.   |
|  | Physician/surgeon fees                           | 20% 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                               | 20% 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 | 20% coinsurance after deductible          | 40% coinsurance after deductible       | See your plan's Certificate of Coverage for details    |
|  | Childbirth/delivery facility services     | 20% 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>          | 20% coinsurance after deductible          | 40% coinsurance after deductible       | See your plan's Certificate of Coverage for details    |
|  | <a href="#">Rehabilitation services</a>   | 20% coinsurance after deductible          | 40% coinsurance after deductible       | See your plan's Certificate of Coverage for details    |
|  | <a href="#">Habilitation services</a>     | 20% coinsurance after deductible          | 40% coinsurance after deductible       | See your plan's Certificate of Coverage for details    |
|  | <a href="#">Skilled nursing care</a>      | 20% coinsurance after deductible          | 40% coinsurance after deductible       | See your plan's Certificate of Coverage for details    |
|  | <a href="#">Durable medical equipment</a> | 20% coinsurance after deductible          | 40% coinsurance after deductible       | See your plan's Certificate of Coverage for details    |
|  | <a href="#">Hospice services</a>          | 20% 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<br>(9 months of in-network pre-natal care and a hospital delivery) |                | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition) |                | Mia's Simple Fracture<br>(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>                                       | \$2,300        | ■ Hospital (facility) <a href="#">coinsurance</a>  | 20%            | ■ Hospital (facility) <a href="#">coinsurance</a>                             | 20%            |
| ■ 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                     |                | Total Example Cost                     |                | Total Example Cost                     |                |
|--|----------------|--|----------------|--|----------------|
|  | \$12,700       |  | \$5,600        |  | \$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> |                |
| Cost Sharing                           |                | Cost Sharing                           |                | Cost Sharing                           |                |
| <a href="#">Deductibles</a>            | \$1,000        | <a href="#">Deductibles</a>            | \$900          | <a href="#">Deductibles</a>            | \$1,000        |
| <a href="#">Copayments</a>             | \$10           | <a href="#">Copayments</a>             | \$900          | <a href="#">Copayments</a>             | \$400          |
| <a href="#">Coinsurance</a>            | \$2,300        | <a href="#">Coinsurance</a>            | \$0            | <a href="#">Coinsurance</a>            | \$100          |
| What isn't covered                     |                | What isn't covered                     |                | What isn't covered                     |                |
| Limits or exclusions                   | \$60           | Limits or exclusions                   | \$20           | Limits or exclusions                   | \$0            |
| <b>The total Peg would pay is</b>      | <b>\$3,370</b> | <b>The total Joe would pay is</b>      | <b>\$1,820</b> | <b>The total Mia would pay is</b>      | <b>\$1,500</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: