14CY1250 - Rx01

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. 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 or call 1- 866-403-2785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: $1,250/Individual, $3,750/Family Out of Network: $3,750/Individual, $11,250/Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible 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 deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care/screening/immunization. Additional details included per service category elsewhere in this SBC.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet a deductible for specific services.
What is the out-of-pocket limit for this plan?	In Network: $4,000/Individual, $12,000/Family Out of Network: $12,000/Individual, $36,000/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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balance billing is prohibited), 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.alliantplans.com or call 1-800-811- 4793 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
		In Network (You will pay the least)	Out of Network (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.	$25 copayment, deductible does not apply	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Specialist visit	$50 copayment, deductible does not apply	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Preventive care/screening/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	Diagnostic test (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 More information about **prescription drug coverage** is available at www.alliantplans.com	Generic drugs	$10 copayment, deductible does not apply	$10 copayment, deductible does not apply	See your plan's Certificate of Coverage for details
	Preferred brand drugs	$20 copayment, deductible does not apply	$20 copayment, deductible does not apply	
	Non-preferred brand drugs	$40 copayment, deductible does not apply	$40 copayment, deductible does not apply	
	Specialty drugs	$40 copayment, deductible does not apply	$40 copayment, deductible does not apply	

If you have outpatient surgery	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 (You will pay the least)	**Out of Network (You will pay the most)**	
If you need immediate medical attention	Emergency room care	$250 copayment, deductible does not apply	$250 copayment, deductible does not apply	See your plan's Certificate of Coverage for details
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Urgent care	$75 copayment, deductible does not apply	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
If you have a hospital stay	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
If you need mental health, behavioral health, or substance abuse services	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	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	See your plan's Certificate of Coverage for details
	Hospice services	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

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

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.)

- Abortion (except in case of rape, incest, or when life of mother is endangered)
- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Cosmetic surgery limited to reconstructive surgery to restore function
- Weight loss programs (4 visits per year for nutritional counseling)
- Chiropractic care - Limited to 20 visits

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, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. 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 .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, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. 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.

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, kwiijigo holne' 1-833-613-2262.

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 your plan's CERTIFICATE OF COVERAGE

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	$1,250
Specialist copayment	$50
Hospital (facility) coinsurance	$2,300
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,620**

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

The plan's overall deductible	$1,250
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other	Not Applicable

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	$900
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$1,250
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other	Not Applicable

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	$1,250
Copayments	$400
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,740**

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:

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