



 **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:
<b>What is the overall <a href="#">deductible</a>?</b>	In Network: \$1,650/Individual, \$3,300/Family Out of Network: Not Applicable	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet a <a href="#">deductible</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In Network: \$7,050/Individual, \$14,100/Family Out of Network: Not Applicable	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 limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a referral
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.alliantplans.com">www.alliantplans.com</a> or call 1-866-403-2785 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness.	20% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.alliantplans.com">www.alliantplans.com</a>	Generic drugs	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Deductibles apply unless stated ' <a href="#">deductible</a> does not apply'. After meeting the <a href="#">deductible</a> , <a href="#">copayments</a> or <a href="#">coinsurance</a> are due. Full drug cost may be required before copayment
	Preferred brand drugs	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not Covered	None

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [[www.alliantplans.com](http://www.alliantplans.com)].]

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)	
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance and 20% <a href="#">coinsurance</a> for other outpatient services	Not Covered	None
	Inpatient services	20% <a href="#">coinsurance</a>	Not Covered	None
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	Not Covered	Office Visits after confirmation of Pregnancy are subject to <a href="#">Coinsurance</a> . <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Office Visits unrelated to Pregnancy are subject to the PCP or Specialist Copay. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not Covered	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not Covered	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not Covered	Limited to 120 visits per year
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	Not Covered	Limited to 40 visits per year
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	Not Covered	Limited to 40 visits per year
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not Covered	Limited to 60 days per year
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	20% <a href="#">coinsurance</a>	Not Covered	Limited to 1 exam per year
	Children's glasses	20% <a href="#">coinsurance</a>	Not Covered	Limited to 1 item per year
	Children's dental check-up	Not Covered	Not Covered	None

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.alliantplans.com](http://www.alliantplans.com).]

## 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
- Chiropractic care
- 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)

**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](#). For more information about your rights, this notice, or assistance, contact: the Georgia Department of Insurance, 1-800-656-2298 or [www.oci.ga.gov](http://www.oci.ga.gov).

**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? Not Applicable.**

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)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,650
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,200

<i>What isn't covered</i>	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$3,910</b>
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### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,650
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$800

<i>What isn't covered</i>	
Limits or exclusions	\$20

<b>The total Joe would pay is</b>	<b>\$2,470</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,650
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$200

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$1,850</b>
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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: