SoloCare Gold PPO $1000 20% Chiro | **Coverage for:Individual or Individual + Family | Plan Type:PPO**

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?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or In Network: $1,000/Individual, $2,000/Family Out of Network: $20,000/Individual, $40,000/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family 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?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP	You don't have to meet a deductible for specific services.
What is the out-of-pocket limit for this plan?	In Network: $7,500/Individual, $15,000/Family Out of Network: Not Applicable	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-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 1-866-403-2785 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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay less)	Non-IHCP 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	$10 copayment/visit, Deductible does not apply	40% coinsurance	None
	Specialist visit	No Charge	$20 copayment/visit, Deductible does not apply	40% coinsurance	None
	Preventive care/screening/immunization	No Charge	No Charge	40% coinsurance	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	$35 copayment, Deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	$150 copayment, Deductible does not apply	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.alliantplans.com	Generic drugs	No Charge	$10 copayment, Deductible does not apply	$10 copayment, Deductible does not apply	Deductibles apply unless stated 'deductible does not apply'. After meeting the deductible, copayments or coinsurance are due. Full drug cost may be required before copayment
	Preferred brand drugs	No Charge	$30 copayment, Deductible does not apply	$30 copayment, Deductible does not apply	
	Non-preferred brand drugs	No Charge	$75 copayment, Deductible does not apply	$75 copayment, Deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay less)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Specialty drugs	No Charge	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	$300 copayment, Deductible does not apply	40% coinsurance	None
	Physician/surgeon fees	No Charge	$300 copayment, Deductible does not apply	40% coinsurance	None
If you need immediate medical attention	Emergency room care	No Charge	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	No Charge	20% coinsurance	20% coinsurance	None
	Urgent care	No Charge	$75 copayment/visit, Deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	$400 copayment/day, Deductible does not apply	40% coinsurance	None
	Physician/surgeon fees	No Charge	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	$10 copayment/visit, Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	Other outpatient services are subject to Coinsurance and may include tests and services not performed in an office visit setting
	Inpatient services	No Charge	$400 copayment/day, Deductible does not apply	40% coinsurance	None
If you are pregnant	Office visits	No Charge	$10 copayment/visit, Deductible does not apply	40% coinsurance	Office Visits after confirmation of Pregnancy are subject to Coinsurance. Cost-sharing

Common Medical Event	Services You May Need	What You Will Pay: Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay: Non-IHCP Provider In-Network Provider (You will pay less)	What You Will Pay: Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
					does not apply for preventive services. 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	No Charge	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	No Charge	$400 copayment, Deductible does not apply	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	40% coinsurance	Limited to 120 visits per year
	Rehabilitation services	No Charge	$35 copayment/visit, Deductible does not apply	40% coinsurance	Limited to 40 visits per year
	Habilitation services	No Charge	$35 copayment/visit, Deductible does not apply	40% coinsurance	Limited to 40 visits per year
	Skilled nursing care	No Charge	20% coinsurance	40% coinsurance	Limited to 60 days per year
	Durable medical equipment	No Charge	20% coinsurance	40% coinsurance	None
	Hospice services	No Charge	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No Charge	20% coinsurance	40% coinsurance	Limited to 1 exam per year
	Children's glasses	No Charge	20% coinsurance	40% coinsurance	Limited to 1 item per year
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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)	• Hearing aids	• Routine eye care (Adult)
• Acupuncture	• Long-term care	• Routine foot care
• Bariatric surgery	• Non-emergency care when traveling outside the U.S.	
• Dental care (Adult)	• Private-duty nursing	

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

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, 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.

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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 plan's overall deductible	**$1,000**
Specialist copayment	**$20**
Hospital (facility) copayment	**$400**
Other copayment	**$10**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,660**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$20**
Hospital (facility) copayment	**$400**
Other copayment	**$10**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$20**
Hospital (facility) copayment	**$400**
Other copayment	**$10**

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

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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