**SoloCare Silver HMO $0 40%** **Coverage for:Individual or Individual + Family | Plan Type:HMO**

**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: $0/Individual, $0/Family<br>Out of Network: Not Applicable | 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<br>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: $1,000/Individual, $2,000/Family<br>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 |
|---|---|---|---|---|
| | | 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. | $0 copayment/visit, Deductible does not apply | 100% coinsurance | None |
| | Specialist visit | $35 copayment/visit, Deductible does not apply | 100% coinsurance | None |
| | Preventive care/screening/immunization | No Charge | 100% 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) | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance, Deductible does not apply | 100% 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 | $0 copayment, Deductible does not apply | $0 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 | $15 copayment, Deductible does not apply | $15 copayment, Deductible does not apply | |
| | Non-preferred brand drugs | 40% coinsurance, Deductible does not apply | 40% coinsurance, Deductible does not apply | |
| | Specialty drugs | 50% coinsurance, Deductible does not apply | 50% coinsurance, Deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| | Physician/surgeon fees | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| | Emergency room care | 40% coinsurance | 40% coinsurance | None |

[* For more information about limitations and exceptions, see the **plan** or policy document at [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) | |
| **If you need immediate medical attention** | Emergency medical transportation | 40% coinsurance | 40% coinsurance | None |
| | Urgent care | $75 copayment, Deductible does not apply | 100% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| | Physician/surgeon fees | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $0 copayment/visit, Deductible does not apply and 40% coinsurance for other outpatient services | 100% coinsurance | Other outpatient services are subject to Coinsurance and may include tests and services not performed in an office visit setting |
| | Inpatient services | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| **If you are pregnant** | Office visits | $0 copayment, Deductible does not apply | 100% coinsurance | Office Visits after confirmation of Pregnancy are subject to Coinsurance. Cost-sharing 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 | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| | Childbirth/delivery facility services | 40% coinsurance | 100% coinsurance | None |
| | Home health care | 40% coinsurance, Deductible does not apply | 100% coinsurance | Limited to 120 visits per year |

| 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** | Rehabilitation services | 40% coinsurance, Deductible does not apply | 100% coinsurance | Limited to 40 visits per year |
| | Habilitation services | 40% coinsurance, Deductible does not apply | 100% coinsurance | Limited to 40 visits per year |
| | Skilled nursing care | 40% coinsurance, Deductible does not apply | 100% coinsurance | Limited to 60 days per year |
| | Durable medical equipment | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| | Hospice services | 40% coinsurance, Deductible does not apply | 100% coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | 40% coinsurance, Deductible does not apply | 100% coinsurance | Limited to 1 exam per year |
| | Children's glasses | 40% coinsurance, Deductible does not apply | 100% coinsurance | Limited to 1 item per year |
| | Children's dental check-up | 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)
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- 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
- Infertility treatment
- 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 | $0 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 40% |
| Other copayment | $0 |

**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 | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,060** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 40% |
| Other copayment | $0 |

**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 | $70 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$190** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 40% |
| Other copayment | $0 |

**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 | $40 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

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: