



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> ?                                | \$0 at Indian Health Care <a href="#">Provider</a> (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; or<br>In Network: \$1,500/Individual, \$3,000/Family<br>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> .                                                                                                                                                                                                                  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care/screening</a> /immunization<br>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?              | \$0 at Indian Health Care <a href="#">Provider</a> (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP                                                                                         | 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: \$8,500/Individual, \$17,000/Family<br>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.                                                                                                                                                                                                                                                                                                                                                                   |
| 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 1-866-403-2785 for a list of <a href="#">network providers</a> .                                                    | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> , in the <a href="#">plan's network</a> . 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 <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). 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                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                |                                                         | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP Provider<br>In-Network Provider<br>(You will pay less)                   | Non-IHCP Out-of-Network Provider<br>(You will pay the most)                |                                                                                                                                                                                                                                                 |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                         | Primary care visit to treat an injury or illness.       | No Charge                                                      | \$15 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply  | 100% <a href="#">coinsurance</a>                                           | None                                                                                                                                                                                                                                            |
|                                                                                                                                                                                | <a href="#">Specialist</a> visit                        | No Charge                                                      | \$30 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply  | 100% <a href="#">coinsurance</a>                                           | None                                                                                                                                                                                                                                            |
|                                                                                                                                                                                | <a href="#">Preventive care/screening</a> /immunization | No Charge                                                      | No Charge                                                                         | 100% <a href="#">coinsurance</a>                                           | 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.                                                       |
| If you have a test                                                                                                                                                             | <a href="#">Diagnostic test</a> (x-ray, blood work)     | No Charge                                                      | \$20 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply  | 100% <a href="#">coinsurance</a>                                           | None                                                                                                                                                                                                                                            |
|                                                                                                                                                                                | Imaging (CT/PET scans, MRIs)                            | No Charge                                                      | \$250 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | 100% <a href="#">coinsurance</a>                                           | None                                                                                                                                                                                                                                            |
| 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="#">www.alliantplans.com</a> | Generic drugs                                           | No Charge                                                      | \$5 <a href="#">copayment</a> , <a href="#">Deductible</a> does not apply         | \$5 <a href="#">copayment</a> , <a href="#">Deductible</a> does not apply  | 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                                   | No Charge                                                      | \$40 <a href="#">copayment</a> , <a href="#">Deductible</a> does not apply        | \$40 <a href="#">copayment</a> , <a href="#">Deductible</a> does not apply |                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                | Non-preferred brand drugs                               | No Charge                                                      | \$50 <a href="#">copayment</a> , <a href="#">Deductible</a> does not apply        | \$50 <a href="#">copayment</a> , <a href="#">Deductible</a> does not apply |                                                                                                                                                                                                                                                 |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                              |                                                                                                                                                    |                                                             | Limitations, Exceptions, & Other Important Information                                                                                           |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP Provider<br>In-Network Provider<br>(You will pay less)                                                                                    | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                  |
|                                                                           | <a href="#">Specialty drugs</a>                  | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                                                                                    | 30% <a href="#">coinsurance</a>                             |                                                                                                                                                  |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | No Charge                                                      | \$400 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply                                                                  | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | No Charge                                                      | \$400 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply                                                                  | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                                                                                    | 30% <a href="#">coinsurance</a>                             | None                                                                                                                                             |
|                                                                           | <a href="#">Emergency medical transportation</a> | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                                                                                    | 30% <a href="#">coinsurance</a>                             | None                                                                                                                                             |
|                                                                           | <a href="#">Urgent care</a>                      | No Charge                                                      | \$75 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply                                                                   | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                             |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No Charge                                                      | \$500 <a href="#">copayment</a> /day, <a href="#">Deductible</a> does not apply                                                                    | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                                                                                    | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                             |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No Charge                                                      | \$15 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply and 30% <a href="#">coinsurance</a> for other outpatient services | 100% <a href="#">coinsurance</a>                            | Other outpatient services are subject to <a href="#">Coinsurance</a> and may include tests and services not performed in an office visit setting |
|                                                                           | Inpatient services                               | No Charge                                                      | \$500 <a href="#">copayment</a> /day, <a href="#">Deductible</a> does not apply                                                                    | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                             |
| If you are pregnant                                                       | Office visits                                    | No Charge                                                      | \$15 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply                                                                   | 100% <a href="#">coinsurance</a>                            | Office Visits after confirmation of Pregnancy are subject to <a href="#">Coinsurance</a> . <a href="#">Cost-sharing</a>                          |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                              |                                                                                   |                                                             | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                    |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP Provider In-Network Provider<br>(You will pay less)                      | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                           |
|                                                                |                                           |                                                                |                                                                                   |                                                             | 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 | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                   | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                                                                                                                      |
|                                                                | Childbirth/delivery facility services     | No Charge                                                      | \$500 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                                                                                                                      |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                   | 100% <a href="#">coinsurance</a>                            | Limited to 120 visits per year                                                                                                                                                                                                            |
|                                                                | <a href="#">Rehabilitation services</a>   | No Charge                                                      | \$40 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply  | 100% <a href="#">coinsurance</a>                            | Limited to 40 visits per year                                                                                                                                                                                                             |
|                                                                | <a href="#">Habilitation services</a>     | No Charge                                                      | \$40 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply  | 100% <a href="#">coinsurance</a>                            | Limited to 40 visits per year                                                                                                                                                                                                             |
|                                                                | <a href="#">Skilled nursing care</a>      | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                   | 100% <a href="#">coinsurance</a>                            | Limited to 60 days per year                                                                                                                                                                                                               |
|                                                                | <a href="#">Durable medical equipment</a> | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                   | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                                                                                                                      |
|                                                                | <a href="#">Hospice services</a>          | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                   | 100% <a href="#">coinsurance</a>                            | None                                                                                                                                                                                                                                      |
| If your child needs dental or eye care                         | Children's eye exam                       | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                   | 100% <a href="#">coinsurance</a>                            | Limited to 1 exam per benefit period                                                                                                                                                                                                      |
|                                                                | Children's glasses                        | No Charge                                                      | 30% <a href="#">coinsurance</a>                                                   | 100% <a href="#">coinsurance</a>                            | Limited to 1 item per benefit period                                                                                                                                                                                                      |
|                                                                | Children's dental check-up                | Not Covered                                                    | Not Covered                                                                       | Not Covered                                                 | None                                                                                                                                                                                                                                      |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                       |                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------|
| • Abortion (except in case of rape, incest, or when life of mother is endangered)                                                                                                                 | • Infertility treatment                                               | • 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 <a href="#">plan</a> document.)                                                      |                                                                       |                            |
| • Chiropractic care 20 visits per year                                                                                                                                                            | • Hearing aids 1 item per 3 years                                     |                            |
| • 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 Tennessee Department of Insurance, 1-800-342-4029 or [www.tn.gov/commerce/insurance](http://www.tn.gov/commerce/insurance), 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 Tennessee Department of Insurance, 1-800-342-4029 or [www.tn.gov/commerce/insurance](http://www.tn.gov/commerce/insurance).

**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.

yes

*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> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$30    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">copayment</a>                               | \$15    |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,560</b> |

### 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> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$30    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">copayment</a>                               | \$15    |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$0          |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$20         |
| <b>The total Joe would pay is</b> | <b>\$720</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$30    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$500   |
| ■ Other <a href="#">copayment</a>                               | \$15    |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,100</b> |

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.